Health Care Financing Grants and Contracts Report

National Hospital Rate-Setting Study, Vol. IV

Case Study of Prospective Reimbursement in Massachusetts

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Case Study of Prospective Reimbursement in Massachusetts

This report was made pursuant to contract No. 500-78-0036 between Health Care Financing Administration and Abt Associates Incorporated, Cambridge, Massachusetts.

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MASSACHUSETTS

Although the Massachusetts Rate Setting Commission (MRSC) has been in existence since 1968, it did not begin prospective budget review and rate setting for hospitals until 1974. An independent state agency, MRSC also has rate-setting responsibility for institutions other than hospitals (e.g., nursing homes, community health centers, day care centers). Three full-time commissioners are appointed by the Governor and are supported by a full-time staff. MRSC operates two distinct prospective reimbursement programs for hospitals. Under one program, prospective payment rates are set for Medicaid patients. Under the other (referred to as the 409 program) MRSC prospectively reviews and approves hospital budgets to contain the increases in charges paid by commercially insured and uninsured patients.

The analytic procedures used in the 409 program have evolved over time. Initially only cost-to-charge ratios were reviewed. Since 1978, operating and capital budgets plus working capital requirements have been reviewed, to determine an approved level of net patient revenue. Base-year operating budgets are scrutinized to disallow patient reimbursement for certain expenses (e.g., research cost). Actual cost in the year prior to the base year, adjusted for inflation, is compared to scrutinized base-year cost. The lower of the totals two is inflated to project the maximum allowable budget in the rate-setting year. Capital budgets and working capital requirements are reviewed against relatively simple criteria. For 1980 budgets, interhospital cost comparisons will be added to the 409 review process.

The rate-setting process for Medicaid is very mechanical, involves no negotiation with hospitals, and applies far more stringent review criteria than does the 409 program. More costs (e.g., bad debt, free care, working capital are disallowed for reimbursement under the Medicaid program. Rate-year projections are based on the lowest of scrutinized base-year cost and actual costs, adjusted for inflation in the two preceding years. No adjustments are allowed for increases in volume between the base and rate years. Hospitals with low occupancy rates are penalized. Reimbursement for outpatient services is reduced by disallowance of one year's inflation in projections of outpatient cost. Finally, the Medicare limitation on general routine service cost has recently been incorporated into the Medicaid rate-setting process.

Because of the nature of the two programs, the issue of compliance is more important for 409 than for Medicaid. Medicaid reimburses hospitals at the rates approved by the Commission. Compliance is automatic, for hospitals cannot generate more revenues than rates allow. The original plan for enforcing decisions of the 409 program was to deduct at least part of excess revenue in the base year from the approved maximum revenue in a subsequent year. The program, which was intended to recoup excess revenue through such a retrospective adjustment was eroded, however, by a recent court decision. A satisfactory mechanism for enforcement has still not been found, although the Commission can take hospitals to court to prevent continuation of overcharging.

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The authors would like to acknowledge that information for this case study was provided through personal and telephone interviews, correspondence, and secondary data supplied by many people. A list of these people is included in Appendix D of this report.

The authors would like to especially acknowledge the following people for the generous amount of time and effort they contributed to our knowledge:

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(Former Hospital Bureau Director, Massachusetts Rate Setting Commission)

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(Former Commissioner, Massachusetts Rate Setting Commission)

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FOREWORD

The following case study report of prospective reimbursement in Massachusetts has been written as part of the National Hospital Rate-Setting Study. This study is being conducted for the Office of Research, Demonstrations, and Statistics of the Health Care Financing Administration, U.S. Department of Health, Education, and Welfare, by Abt Associates Inc., Policy Analysis, Inc., and Health Economics Research, Inc.* The overall goal of the three-year study is to determine the impact of rate setting on hospital costs, quality of hospital care, and access to health care by the elderly and the economically disadvantaged. In addition, the study will examine the impact of prospective reimbursement on other areas of hospital performance, including revenues, volume and composition of services, productivity, wages, case mix, and administrative behavior. Because the effects of prospective reimbursement may be felt beyond the hospital sector, the study will also examine impacts on the costs and utilization of the health care system as a whole.

This volume is one of nine case study reports (Arizona, Connecticut, Maryland, Massachusetts, Minnesota, New Jersey, New York, Washington, and Western Pennsylvania). Each report examines in detail the adoption, implementation, review processes and legal challenges of each prospective reimbursement system. In addition, the reports examine linkages and interactions that take place between rate-setting agencies and other organizations such as planning groups, hospital associations, third party payors, and unions. Each case study also presents a preliminary analysis of the potential rigor and equity of the prospective reimbursement system. (A separate report, A Comparative Analysis of Nine Prospective Reimbursement Programs, analyzes all nine programs simultaneously along these factors.) The case study reports will be most useful to those interested in a detailed description of the prospective reimbursement programs in the nine states under study.

The preliminary analyses of rigor and equity in the case studies are interim in nature. Data collection on hospital performance is still ongoing and will yield important information about the effectiveness of administrative structures and procedures in containing costs and delivering quality service. Final results of the study are expected in 1982.

Diane E. Hamilton
Deputy Project Director &
Director of Case Studies
National Hospital
Rate-Setting Study

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*Arthur D. Little, Inc. and Arthur Andersen & Co. are also participating in the National Hospital Rate-Setting Study but were not involved in the case studies.

INTRODUCTION

General System Characteristics

Prospective rate setting in Massachusetts consists of two separate, mandatory systems. The first system, implemented in 1974, was designed to control Medicaid expenditures. The second system was initially introduced in the form of temporary charge controls for private payors and commercial insurors in 1975. The latter system was superseded in 1976 by a permanent budget review/charge control system, known as the 409 system. Together, the Medicaid system and Chapter 409 control approximately thirty percent of Massachusetts hospital expenditures.

Both systems are under the purview of the Massachusetts Rate Setting Commission, a state agency within the Executive Office of Human Services. The Commission is comprised of three full-time commissioners and a full-time staff.

The Medicaid system is a formulary system that sets an all-inclusive *per diem* rate. The 409 system, still in its evolutionary stages, is a combined budget review and charge approval system which has historically approved a cost-to-charge ratio, but now approves a hospital's net patient service revenue. This change, instituted in 1978, is the first of several legislatively mandated changes to be instituted in the charge control system. Hospital groupings and cost comparisons were slated for 1979 as well as uniform reporting of hospital data, both of which are in the process of being implemented. Full payor participation, which is not legislatively mandated, is the subject of much controversy and is not anticipated prior to 1980.

To date, all parties agree that both prospective systems have contributed to a reduction in the hospital cost inflation rate in Massachusetts, but the extent of their contribution has yet to be assessed.

Overview of the Case Study

The remainder of this section examines health care costs in Massachusetts and trends in hospital costs in Massachusetts as compared to those in the nation. A discussion of the historical background to rate setting in Massachusetts and a description of the political and financial pressures leading to adoption are presented. In the second section, the organization of the Massachusetts rate-setting process is examined.

The third section describes the specific methodology of the 409 system and the mechanics of the budget review process, as well as the Medicaid system. The section also describes the timing and resources for both systems.

Legal challenges to both systems are discussed in the fourth section. The fifth section describes the interactions among the various agencies and organizations involved in prospective rate setting in Massachusetts. The sixth section contains a preliminary assessment of the rigor, equity, and efficiency of both systems, and a discussion of future developments is presented in the final section.

Health Care Costs in Massachusetts[1]

In this section the trends in health care expenditures in Massachusetts specifically affecting hospital costs are examined. Cost containment initiatives undertaken by the Commonwealth to date are also discussed in order to provide a context for understanding the activities of the Rate Setting Commission, described later in this case study.

One year prior to the implementation of the Massachusetts prospective Medicaid system, health care expenditures in the state amounted to approximately $3.5 billion. As shown in Figure 1, this figure rose to $4.9 billion in fiscal year (FY) 1976, the year when charge controls were first introduced in Massachusetts. This equals eleven percent of the gross state product compared to a national proportion of 8.6 percent. Figure 2 illustrates the large difference between Massachusetts' and the nation's per capita expenditures from 1973 through 1976. In 1976, per capita expenditures amounted to $845 per state resident, which was thirty percent higher than the national average.

Massachusetts' health care expenditures exceeded national levels in all major categories (i.e., supplies, services, research). It is interesting to note, however, as pointed out in the Massachusetts State Health Plan, that the differential between Massachusetts and the nation has either remained roughly constant or declined. A case in point is the Massachusetts Medicaid program. In 1973, Medicaid spending in Massachusetts on a per capita basis exceeded the national level by seventy-one percent. In 1976, this had dropped to seventy percent. Expenditures for general hospital care and medical care on a per capita basis also declined from twenty-two percent above the U.S. level in 1973 to parity with the nation in 1976. The Office of State Health Planning, however, does note that, "since Massachusetts expenditures in these areas increased from 1973 to 1976, it can be assumed that the rest of the nation is 'catching up' with Massachusetts."

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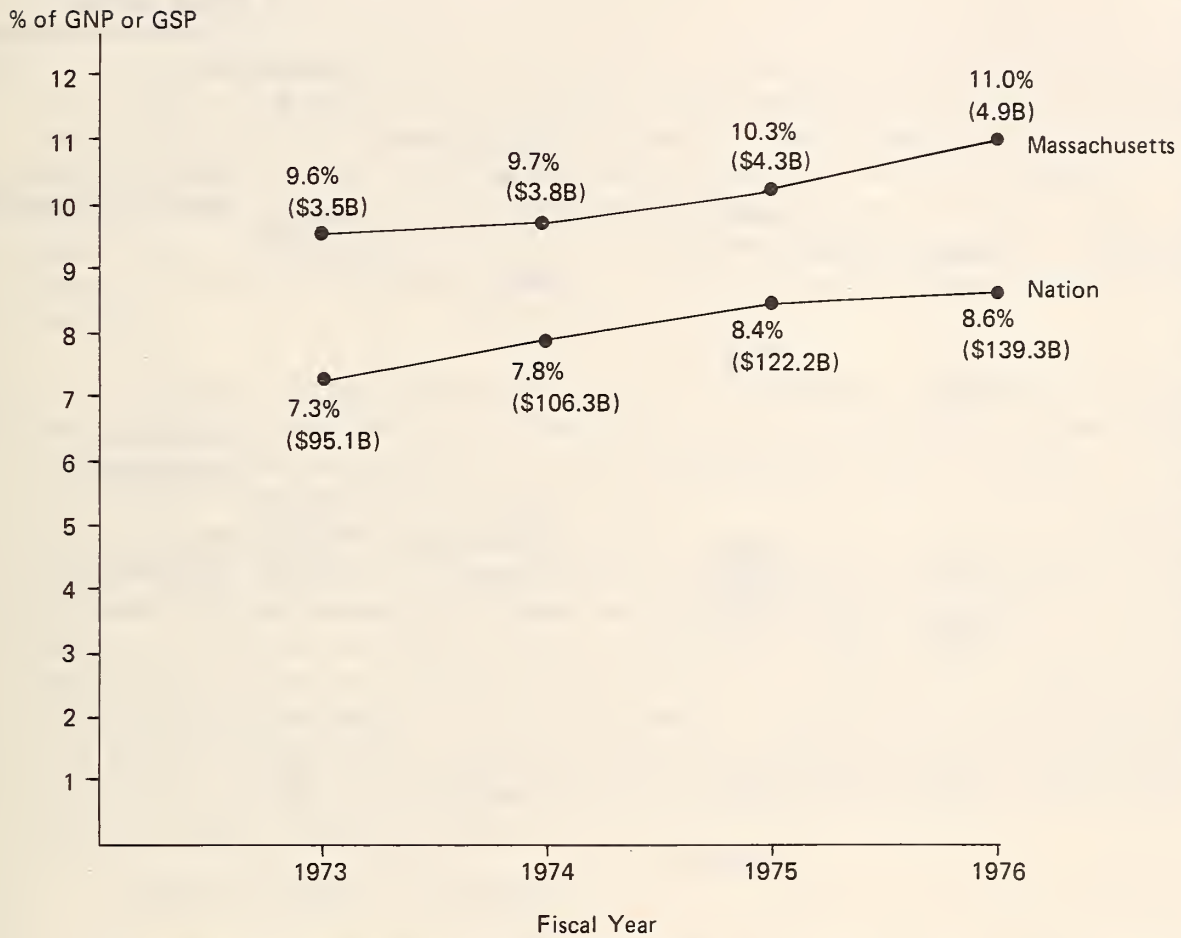
[1]The data source for this section is the draft State Health Plan: Economics and Finance Component. Data for Massachusetts are drawn from Donald S. Shepard and Anestis J. Ghanotakis, Massachusetts Funds Flow Project, Office of State Health Planning, 1978.

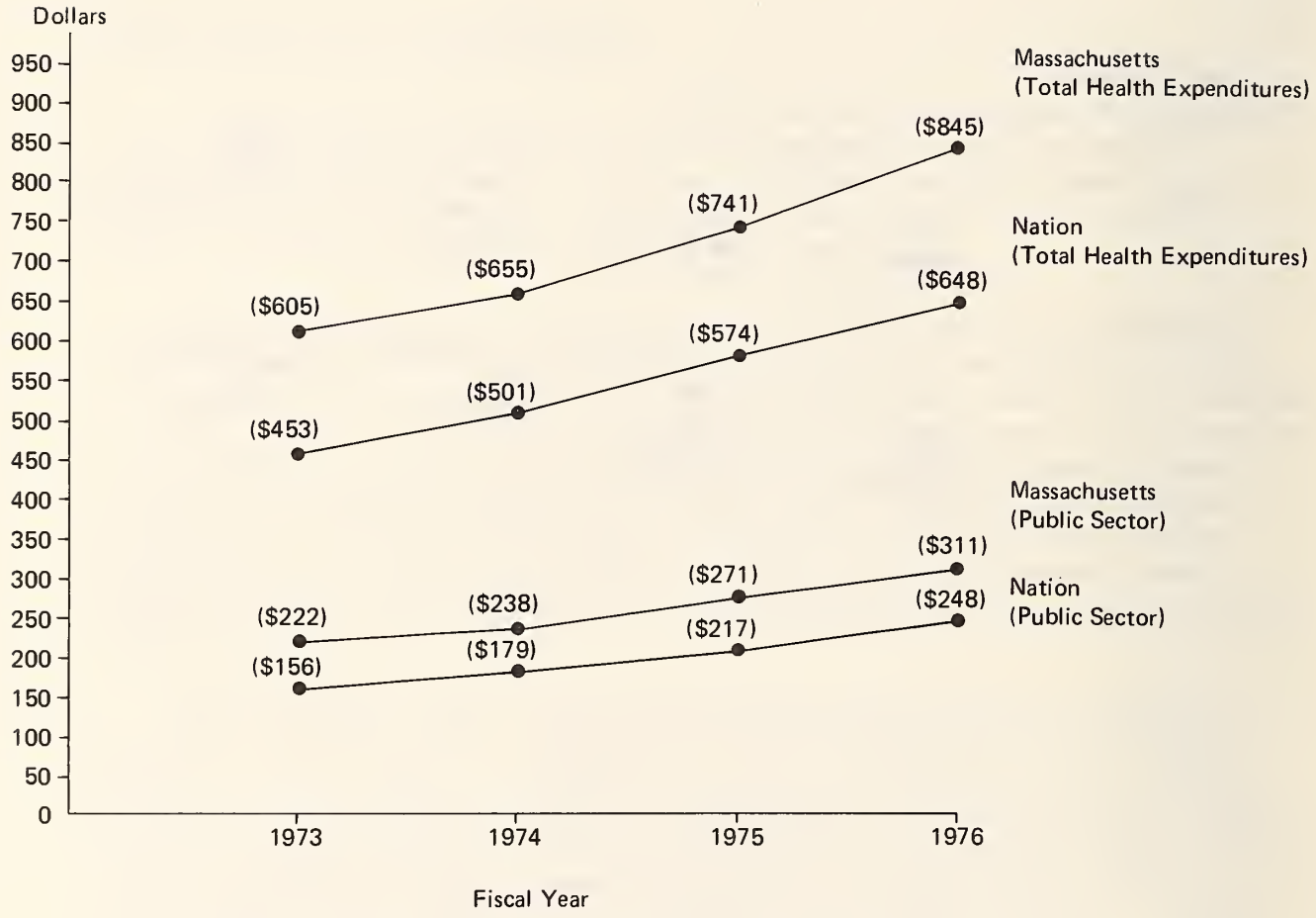
Figure 1
HEALTH EXPENDITURES AS A PERCENT OF THE
GROSS NATIONAL PRODUCT AND GROSS STATE PRODUCT
Fiscal Years 1973 - 1976



Source: Donald S. Shepard and Anestis J. Ghanotakis, Massachusetts State Health Plan, Massachusetts Funds Flow Project, Office of State Health Planning, 1978.

Note: Massachusetts data are provisional. Figures in parentheses represent billions.

Figure 2
PER CAPITA HEALTH EXPENDITURES IN MASSACHUSETTS AND THE NATION
Fiscal Years 1973–1976



Source: Donald S. Shepard and Anestis J. Ghanotakis, Massachusetts State Health Plan, Massachusetts Funds Flow Project, Office of State Health Planning, 1978.

Note: Massachusetts data are provisional. Figures in parentheses represent billions.

Comparative Trends in Massachusetts Hospitals

In this section, a number of relevant characteristics of the hospital industry in Massachusetts are discussed. Trends over time and comparisons between the state and the nation are examined for the following variables: total number of beds, total patient days, occupancy, length of stay, expense per patient day, assets per bed, and expenses per capita (see Figures 3 and 4).

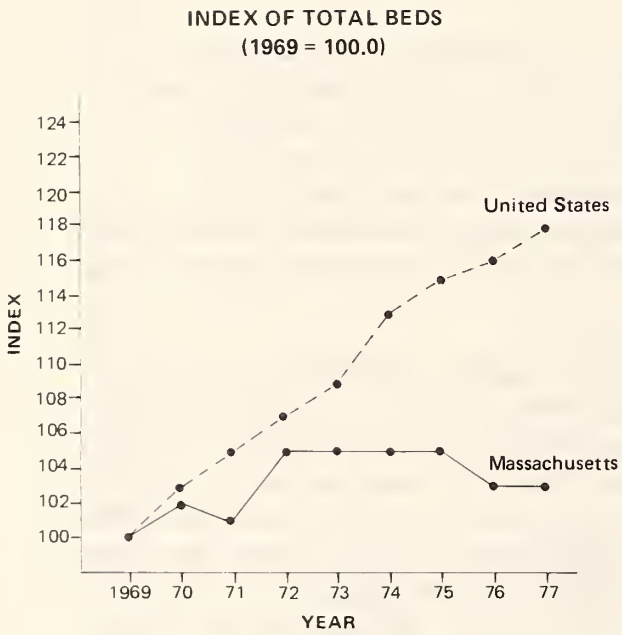
The number of beds and patient days in Massachusetts has increased at a slower rate than in the nation. While length of stay has decreased nationally over the years, in Massachusetts it has remained relatively constant (8.9 days in 1969 and 8.5 days in 1977). As can be seen in Figure 3, the occupancy rate in Massachusetts has not declined at the same rate as the national average; it remained at approximately seventy-nine percent in Massachusetts as compared to the national average of seventy-four percent.

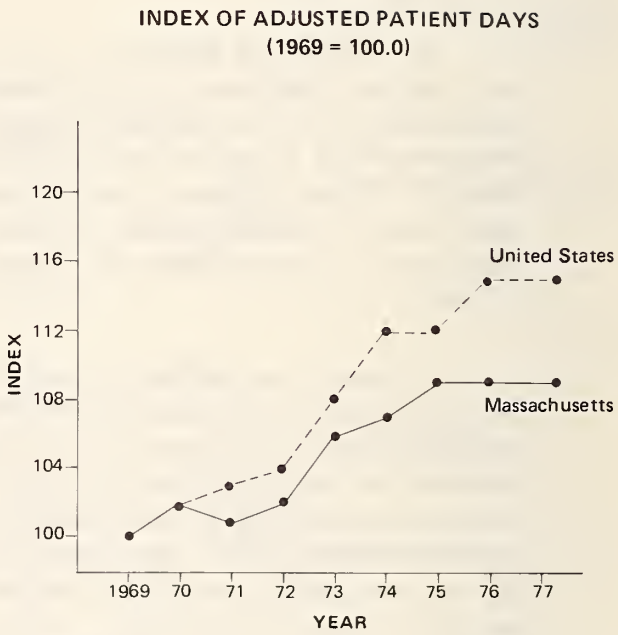
Expenses per adjusted patient day have increased in absolute numbers per year as in the nation. However, the percentage variance between Massachusetts and the nation still remains approximately thirty percent. Finally, revenue per adjusted patient day, assets per bed, and expense per capita have remained higher in Massachusetts than in the nation. In comparing Massachusetts to the nation, 1977 data indicate that Massachusetts exceeds the nation by twenty-eight percent in revenue per adjusted patient day and by forty percent in assets per bed. While 1977 data for total expense per capita in Massachusetts are not available, data for 1976 indicate that expense per capita was approximately forty-seven percent higher than that for the nation. (It should be noted that trends in the graphs should not be attributed necessarily to the prospective systems in Massachusetts, as other effects have not been controlled for.)

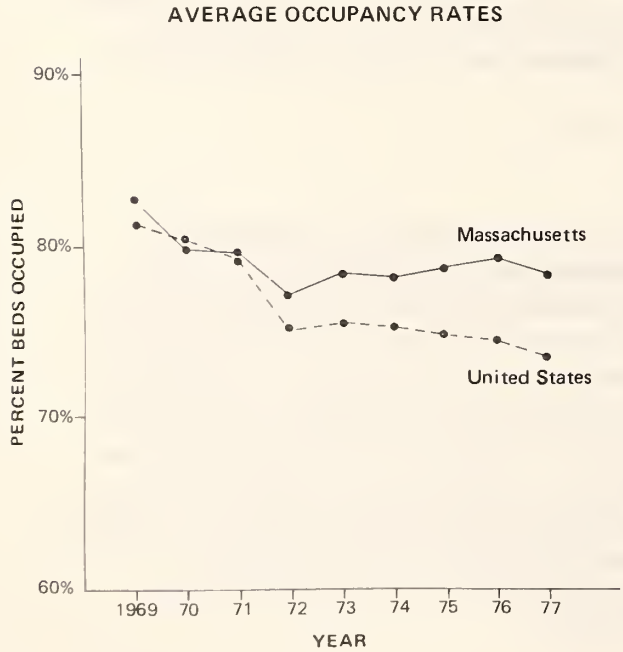
Cost Containment Initiatives

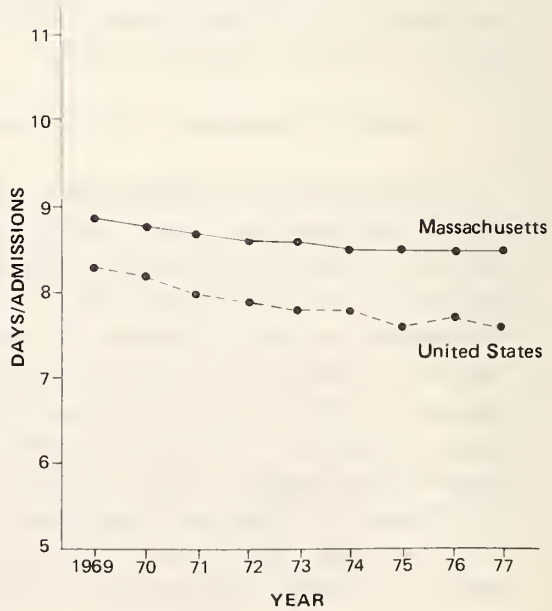
A number of regulatory mechanisms have been instituted to slow the spiraling hospital cost inflation in Massachusetts. A strong Certificate of Need (CON) program was instituted in 1971 and has been strengthened over the years to the extent that capital expenditures in excess of $150,000, or increases in bed capacity of four or more beds, are now subject to approval by the Department of Public Health. The program has suffered several setbacks, however, due to preemptive legislation. Also, the Medicaid program has instituted a mandatory second surgical opinion program to further cut back on expenses. Other factors to be considered when analyzing the changes in hospital costs in Massachusetts are mandated utilization review by Professional Standards Review Organizations (PSROs) and increased enrollment in Health Maintenance Organizations (HMOs).

Figure 3
COMPARISON OF HOSPITAL INDICATORS:
Capacity, Volume of Service and Utilization for Community Hospitals, 1969-1977
MASSACHUSETTS vs. U.S.





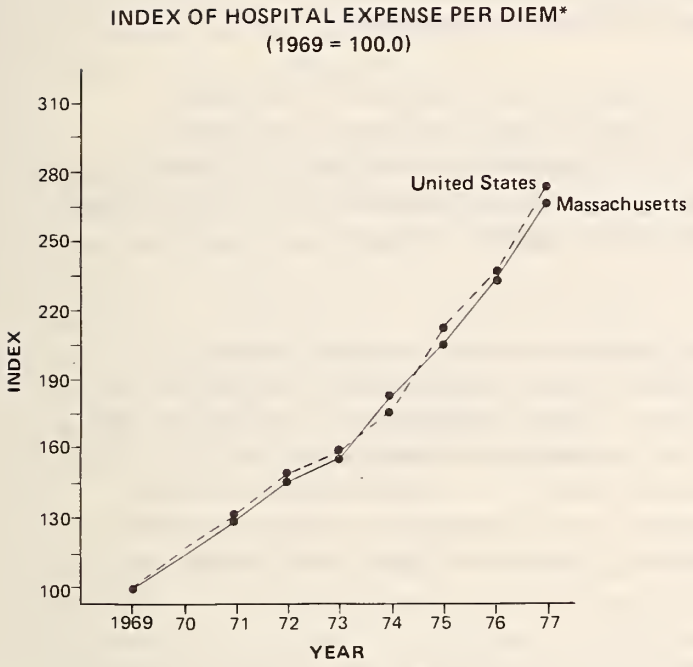


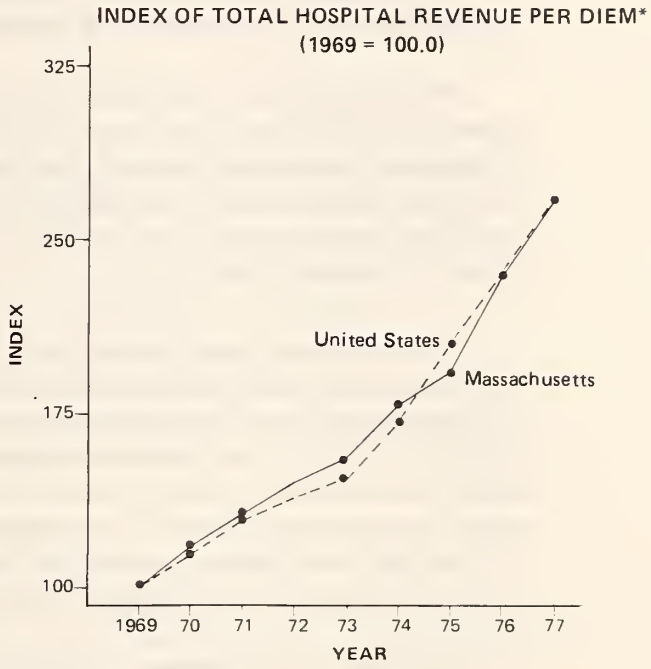


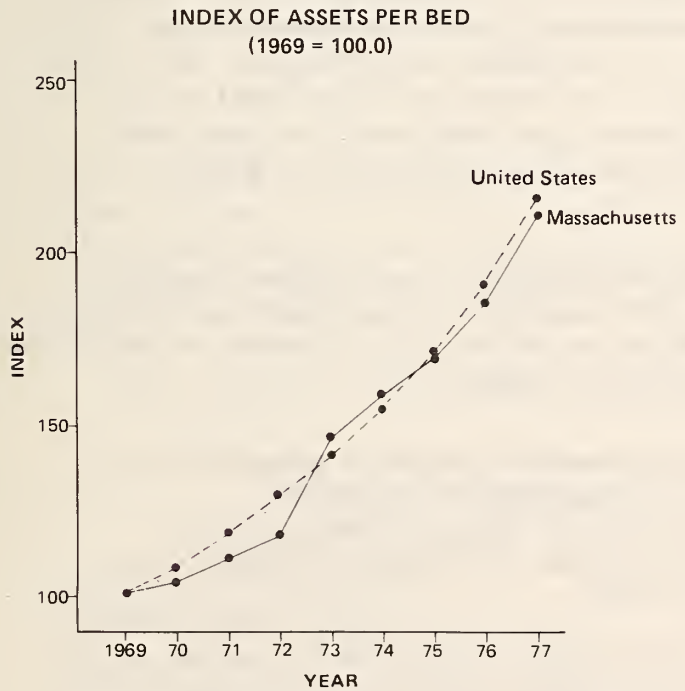
Sources: U.S. Bureau of the Census
American Hospital Association, *Hospital Statistics*

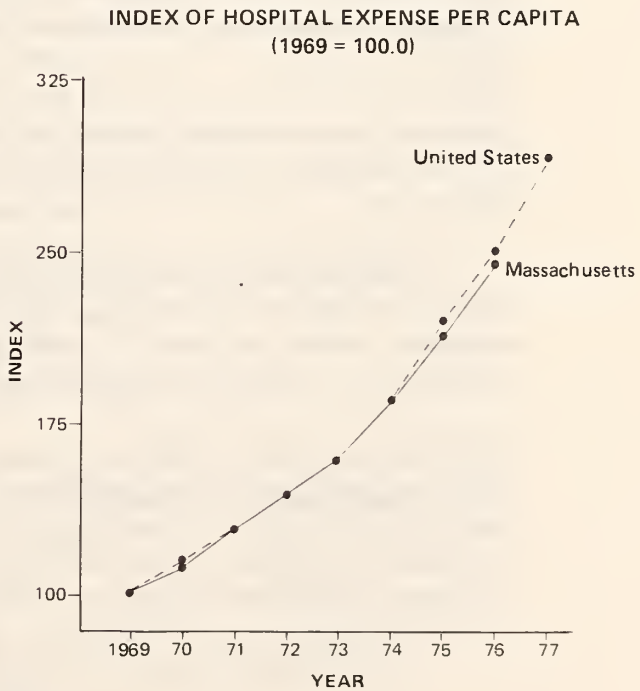
Figure 4

COMPARISON OF HOSPITAL INDICATORS:
Expense, Total Revenue and Assets
for Community Hospitals, 1969-1977
MASSACHUSETTS vs. U.S.









*Per adjusted patient day.

Sources: U.S. Bureau of the Census

American Hospital Association, *Hospital Statistics*

While a number of regulatory initiatives have been instituted since the early 1970s, "a stable set of policies to ensure the continued abatement of hospital inflation" is not yet in place.[1] As will be detailed in the discussion to follow, regulations under the Massachusetts rate-setting authority are still in the evolutionary stages.

Historical Background to Hospital Rate Setting in Massachusetts

Political and Financial Pressures Leading to Adoption

Massachusetts hospitals have had some form of control over their payment rates since the mid-1950s.[2] At that time, the Bureau of Hospitals set rates of payment for services to patients covered by industrial accident insurance and patients eligible for public assistance. The Bureau was also authorized to approve all hospital payment contracts with Blue Cross of Massachusetts.

In 1968, the Massachusetts state legislature merged the Bureau of Hospital Costs with the Bureau for Long-Term Care Facilities to establish the Massachusetts Rate Setting Commission. The Commission, located in the Executive Office for Administration and Finance, was comprised of five part-time commissioners and a full-time staff. The Commission's general mandate was that of setting payment rates for industrial accident coverage and public assistance rates for hospitals, long-term care facilities, and noninstitutional providers of health.

Significant changes in the state's fiscal situation in 1974 set the stage for a new, more aggressive approach to regulating health care expenditures. As part of a massive reorganization of state government, the enabling legislation of the Rate Setting Commission was amended. The authority of the Commission was expanded and three full-time commissioners replaced the five part-time commissioners. The Commission was also moved to its present location within the Offices of the Secretary of Human Services.

A second development in 1974 was the lifting of the federal Economic Stabilization Price and Wage Program Control (ESP). Significant increases in hospital costs followed in Massachusetts, as in many other states, as hospitals attempted to regain any losses incurred due to ESP.

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[1] J. Fielding and S. Weiner, "Controlling Hospital Costs in Massachusetts," New England Journal of Medicine, Vol. 299, November 30, 1978.

[2] See also K. Bauer, "Information Available For Hospital Rate Setting in Massachusetts." Harvard University Center for Community Health and Medical Care Report Series. R-45-9, 1976.

Adoption of Medicaid Prospective System

The year 1974 also saw the Commonwealth take aggressive steps to overcome the Medicaid budgetary crisis that had mushroomed over the years. It is important to understand the dimensions of the Medicaid budgetary problems because they initially set the stage for the introduction of the Medicaid prospective system and the charge control program in Massachusetts. Furthermore, the state Medicaid budget continues to exert a tremendous influence on the implementation and the methodological changes in the charge control system over the years.

The Medicaid program in Massachusetts is an extremely rich one in terms of scope of coverage and benefits; the fiscal pressures of offering such a program have burdened the state for the past ten years. In 1968, the Medicaid budget was considered the most critical problem faced by the administration. By 1972, the program became seriously delinquent in its payments to hospitals, causing serious cash flow problems. The Rate Setting Commission was faced with two problems: first, the Medicaid program was not in compliance with federal Medicaid regulations because of its nonpayment to hospitals; second, hospitals were bringing suit against the Department of Public Welfare for back payments owed.[1]

It was at this point that the Commission began considering the use of prospective rate setting. The Massachusetts Hospital Association had already endorsed the concept of prospective rate setting and had developed, in cooperation with Blue Cross, a proposal for "prospective rate determination." Hospitals also were certainly receptive to changing to "a more reliable and predictable rate setting and payment alternative," given their experience with what has been termed the Commonwealth's "discounted cost pass-through method" of Medicaid reimbursement.[2]

The state sought relief from the fiscal pressures of the Medicaid program by applying for a Department of Health, Education and Welfare (DHEW) waiver from the prescribed cost reimbursement methodology. The waiver was granted, and in April 1974, the Commission operationalized a "prospective" system of reimbursement for all inpatient and outpatient hospital care and services rendered to publicly assisted patients.

The specific objectives of the prospective system were to:

- keep inflation in hospital costs at the same level as inflation of wages and prices in the economy as a whole and

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[1]K. Bauer, op. cit.

[2]W. J. Sahlern, "Prospective Rate Setting for Hospital Care Provided to Publicly Aided Patients." Executive Office for Administration and Finance, Commonwealth of Massachusetts. 1973.

- stop subsidizing excessive costs of underutilized hospital services.[1]

The continuing escalation of medical costs and a depressed economy were the primary problems facing the new administration in 1975. Massachusetts, under its combined Medicaid and General Relief Medical Care Programs, was spending $470 million a year on all health services; payments to hospitals represented about forty percent of those expenditures. Faced with an annual deficit of $500 million, the Governor began a major initiative to bring the state's budget under control.[2]

The Medicaid budget was again the target for some type of control. Although the Medicaid prospective reimbursement methodology had begun to exert some degree of control over Medicaid payments, the administration realized that Medicaid payments represented only about fifteen percent of total hospital revenue. Furthermore, it became obvious that there were problems in the Medicaid prospective methodology. Foremost was its inability to control the hospital's base costs over time; hospitals were shifting costs to other payors and thus incurring costs in excess of those allowed under Medicaid. The effect of these costs on the Medicaid program became evident two years later, when they became the base on which the Medicaid rate was established.

Adoption of Charge Control System

Within his four-part program to improve the fiscal situation of the Commonwealth, the Governor requested authority from the legislature to impose an immediate, emergency fifteen-month freeze on all hospital charges throughout the state. This rather drastic measure was basically a strategic move designed to initiate the development of a Medicaid cost control system that would include the capacity to control total hospital expenditures. Hospitals joined forces to oppose the freeze, but as a compromise, supported an interim charge control bill. The interim bill, known as Chapter 424, was based on cost limitation provisions of the current Blue Cross contract. Enacted in July and effective in August 1975, Chapter 424 was definitely viewed as a temporary measure to stabilize hospital charges pending the enactment of some kind of comprehensive and permanent cost and charge control legislation.

It is clear that the impetus for enacting Chapter 424 came from the need to curb spiraling Medicaid expenditures in the state. The Rate Setting Commission and the Governor were convinced that one way to control the Medicaid budget was to obtain total budget review authority and thereby slow the rapid growth in the size and number of hospitals, as well as the

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[1]K. Bauer, 1976, op. cit.

[2]David M. Kinzer, "Health Controls Out of Control: Warning to the Nation," 1977.

aggregate cost of hospital care in the state. Another key concern was that of rising Blue Cross premiums, which were increased by forty percent in 1975.

Chapter 424 of the Acts of 1975 was enacted in July, effective in August 1975, and was in effect through 1976. The law established the statutory foundation for the implementation of an interim hospital charge review system until such time as a more carefully developed charge control law could be developed and implemented.[1] The strategy adopted was one of controlling costs by controlling charges.

There were three key provisions to Chapter 424. First, the law established a charge review system on an exception basis. That is, under Chapter 424 and its ensuing regulations, hospitals were required to submit any proposed modification of their charges to the Rate Setting Commission, and Commission approval had to be secured before new charges were implemented. Second, the law established criteria for charge approval; the Commission was to approve a hospital's proposed charge modifications and proposed budget only if its ratio of total patient care costs to total patient care charges for the rate year was not lower than ninety-five percent or the hospital's ratio year ratio, if that were lower.[2] The third key provision was that Chapter 424 mandated that the Secretary of Human Services submit a comprehensive cost/charge control plan by October 1, 1975, three months after the effective date of Chapter 424.

As mandated in Chapter 424, the Secretary of Human Services submitted a plan to the Joint House and Senate Health Committee in October 1975. Final action on the bill was not taken, however, until the final hours of the 1976 legislative session. The following is a brief discussion of the legislative process that ensued.

The legislative activity for the development of the permanent system was coordinated through the Joint Health Care Committee. The Committee was jointly chaired by individuals with opposing views on hospital regulation. In the formation of the permanent legislation, the Committee attempted to mitigate the pervasive influence of the Boston teaching hospitals and the Massachusetts Hospital Association. A series of six meetings were conducted throughout the state to discuss the bill, obtain opinions, and educate the smaller community and rural hospitals. Unfortunately, these hospitals mounted uniform opposition, thus preventing the Committee from having constructive input. The groups that influenced the legislation, therefore,

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[1] K. Bauer, 1976, op. cit.

[2] As specified by statute, the ratio year was designated as the period from April 1, 1974 to March 31, 1975. A more in-depth discussion of the 424 methodology may be found in the section on the evolution of the charge control system.

remained the large interest groups, the Massachusetts Hospital Association (MHA), Blue Cross, and some commercial carrier representatives.

Key provisions of the bill that had been designed by the Commission and submitted by the Secretary of Human Services were as follows:

- extensive involvement of HSAs in the rate-setting process through appropriateness reviews and volume projections,
- uniform payment system, and
- compliance.

The bill was far reaching and comprehensive; the planning and regulatory processes were integrated, and all payors were to be included in the system.

The Committee chairman in the House (who was in favor of regulation) had taken the lead in the formation of 424. However, during the early stages of 409, he was on leave and the Senate chairman, who was favorably inclined toward hospitals, redrafted the Governor's bill to reflect his bias. This bill incorporated a number of key provisions lobbied for by the hospital industry, one of which was a policy review board with the authority to give or withhold approval of Commission regulations. When the House chairman returned, he was faced with a prohospital bill that was on its way toward becoming law. He and the other House members "reserved their right" to vote on the bill. (This is a mechanism that allows a member to express disagreement on the provisions of the bill and may be used while a bill is in committee.) Nevertheless, the bill passed and went to the Committee on Ways and Means. The chairman of that committee had sympathies more in line with those of the House chairman and gave him a chance to redraft the bill. The redraft encountered no opposition and became the permanent legislation (409). The most probable reason why the new version passed so easily was the "lateness of the hour," which did not allow opposing interests an opportunity to redress. The final version of Chapter 409, although much tougher on the hospital industry than its immediate predecessor, was still a considerably milder version of the original bill drafted by the Commission.

The final compromise had been the subject of much negotiation among four components in the health care system: Blue Cross, the Department of Human Services, the Massachusetts Hospital Association, and, to a very limited extent, private insurance companies.[1] The final bill severely

[1]Within the Department of Human Services, the Rate Setting Commission and the Department of Public Health were extensively involved in negotiating the final bill.

curtailed the role of the planning agencies' function to one of review and comment; the hospital industry did not consider the planning agencies ready to assume any larger role in the process. The uniform rate concept was eliminated; Blue Cross was not ready to support this change, and the state Medicaid office was certainly not in a position to commit itself to such an arrangement. Provision for a Hospital Policy Review Board, to include key health care providers, was included, but the authority to sign off and approve regulations as promulgated by the Commission was changed to a basic review and comment function. Mandatory consultation with industry representatives prior to the promulgation of rules and regulations was also included in the procedure.

The bill required that all hospitals submit budgets as of October 1978. The bill also put forth an evolutionary approach to the development of a prospective system by calling for major changes to be implemented over time. Specifically, the Commission was to move by FY 1979 from approval of a hospital's cost-to-charge ratio to approval of a hospital's reasonable financial requirements. Development of a mechanism to group hospitals in order to implement cost comparisons was scheduled for FY 1980. The bill also established the Commission's authority to implement a uniform accounting and reporting system.

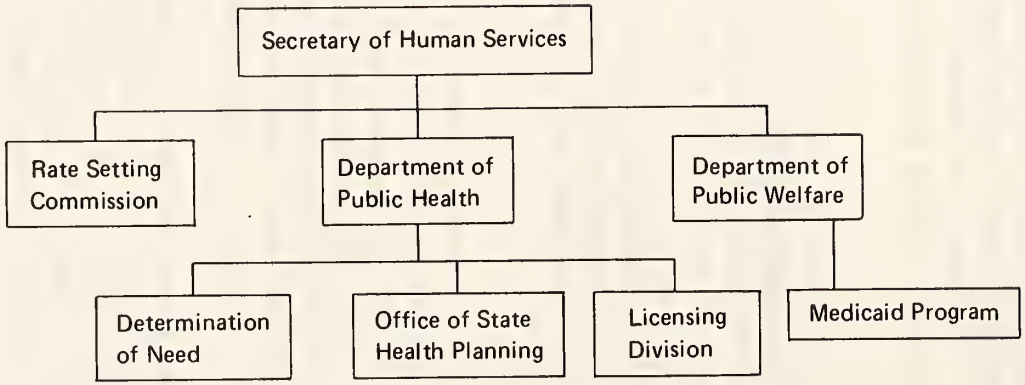
For the transition year (FY 1978), it was decided to utilize the existing methodologies, which were familiar to both hospitals and staff. The first year of Chapter 409 became one of development and evaluation of detailed refinements to the system. It was during this transition year that the Rate Setting Commission was also awarded a federal contract from the Social Security Administration (now the Health Care Financing Administration) to develop refinements to the prospective reimbursement system.

Thus, by 1975 (FY 1976), the Commission was administering two prospective rate-setting systems: the Medicaid system adopted in 1974, and the interim charge control system adopted in 1975, to be superseded by Chapter 409 in the following year. The following section examines the organizational context within which the rate-setting program is administered.

COMMISSION AUTHORITY AND STRUCTURE

The Massachusetts Rate Setting Commission is an independent governmental agency located within the state Executive Office of Human Services. As shown in Figure 5, the Departments of Public Health and Public Welfare are also situated within this umbrella agency. The executive office oversees the activities of those state agencies involved in the purchase, regulation, and delivery of human services.

Figure 5
ORGANIZATION OF EXECUTIVE OFFICE OF HUMAN SERVICES



Source: Massachusetts Rate Setting Commission
Note: This does not reflect the entire organization of the Department of Human Services.

General Structure

The Commission has evolved over time from having part-time commissioners to its present full-time-commissioner structure. Unlike many existing rate-setting authorities, the Massachusetts Commission is made up of four programmatic bureaus: hospitals, long-term care facilities, community and noninstitutional providers, and education and social services. Within the Commission there are also three support groups that serve each of the bureaus. These include a policy and analysis group, a legal department, and an administrative division. Figure 6 displays the organizational structure of the Commission.

Commission Authority

The Rate Setting Commission, under its legislative authority, has four primary responsibilities:

- to establish rates of payment for all health care, education, and social services purchased by the Commonwealth or by political subdivisions of the Commonwealth;
- to determine charges for health care, education, and social services provided by state institutions;
- to review and approve all contracts between Blue Cross of Massachusetts, Inc., and participating providers, and to approve rates and final settlements under these contracts; and
- to review and approve hospital charges.[1]

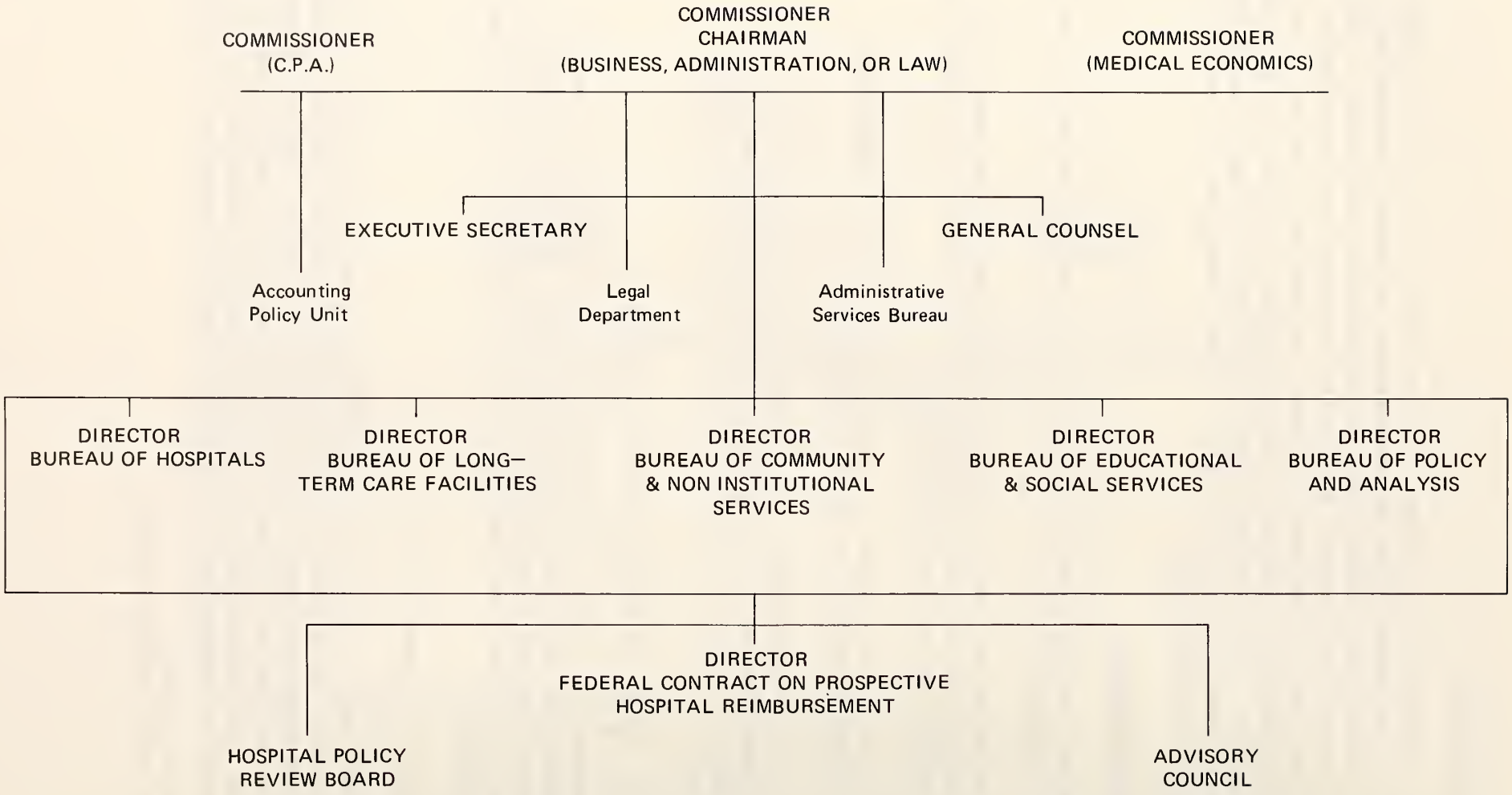
Thus, besides its hospital and clinic rate-setting and charge control responsibilities, which will be described below, the Commission also establishes rates for long-term care facilities, community and home health agencies, noninstitutional medical care providers, and educational and social services.

Role of the Commissioners

As mentioned earlier, the Massachusetts Commission has three full-time commissioners. In accordance with Massachusetts General Law, the chairman of the Commission must have "administrative experience, and an advanced degree in the field of business administration, public administration, or law." One commissioner must be a certified public accountant, and the other is "to be experienced in the field of medical economics." No further

[1]Chapter 409 of the Acts of 1976.

Figure 6
ORGANIZATION OF RATE SETTING COMMISSION



Source: Massachusetts Rate Setting Commission

definition of the qualifications of the commissioners is found in the statute or the regulations. The commissioners, who are salaried, are appointed by the Governor for a term of three years, and no more than two commissioners may belong to the same political party. The Commission is directly accountable to the Governor. Of the original appointees, two were attorneys and the third was a certified public accountant. As will be seen later, both prospective systems have taken an extremely legalistic approach, most likely as a result of the legal background of the commissioners.[1]

The commissioners do not act as staff; rather, they are the policy-making arm of the Commission. The chairman has traditionally been responsible for designing legislative strategy, getting programs authorized, and maintaining the necessary linkages within the health care system. In the first year when there were full-time commissioners, their responsibilities were delegated according to individual backgrounds. The CPA commissioner handled all policy issues concerning auditing and accounting policy; economic and analytic issues were handled by the "medical economist," who in fact was an attorney. By the third year of operation, the commissioners moved to a project management system, under which the "medical economist" commissioner was responsible for the federal grant, the CPA commissioner spent a significant portion of his time in the Long-Term Care Bureau, and the chairman coordinated all Commission projects and maintained external relationships.

Role of the Executive Secretary

The executive secretary's responsibility is for the daily management of Commission affairs. The executive secretary, who is an accountant, is not involved in program or policy issues. Personnel matters, Bureau budgets, filing regulations, and coordination of the vast array of service contracts approved by the Commission all fall under the purview of the executive secretary.

Mechanisms for Input into Commission Activities

The Commission has three formal mechanisms for input into its activities: the Rate Setting Commission Advisory Council, a Hospital Policy Review Board, and a mandatory consultation process. The Advisory Council, which is required to meet three times a year, was established to serve as

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[1]Demands from the hospital association for specificity in regulation are another reason for the legalistic approach taken.

an advisory body for all operations and policy of the Commission.[1] The Council, empowered to review and comment on all proposed regulations, has little, if any, input into the rate-setting policies for the Medicaid or the charge control prospective systems.

Hospital Policy Review Board

The Hospital Policy Review Board (HPRB) was established for the sole purpose of working with the Bureau of Hospitals on Chapter 409 issues. The role of the HPRB is explicitly defined in the Chapter 409 statute: the HPRB is to review and comment on all rules and regulations regarding the budget approval system prior to their implementation. Furthermore, the HPRB is required to report at least annually to the Governor and the legislature on its findings and recommendations concerning legislation. The HPRB is also the formal review authority for all activities of the budget approval system.

The Commission is required to give the HPRB at least sixty days prior review and comment on any proposed rule or regulation applicable to the Bureau of Hospitals. The only exception is in the case of rules or regulations promulgated on an emergency basis.[2] The Board, in accordance with the provisions of Chapter 409, must either approve, disapprove, or issue a partial approval. The Commission, however, is not bound by the Board's decision; it is merely required to issue and submit a written statement to the Board outlining its reasons for disagreement. This statement must be issued within twenty days of the Board's recommendation, and both documents must be included in the record of any public hearing held on the proposed rules or regulations. The Commission must wait twenty days before issuing any rules or regulations not recommended for approval by the Board, during which time the Board may conduct a public hearing on the matter should it so desire.

There are eleven members who serve on the HPRB. The number and type of members, as well as the manner in which they are selected, are specified in the statute.[3] Two of the members are to be chosen by the secretary of

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[1]The Advisory Council consists of seven government officials who are ex-officio members, eight representatives of providers whose rates are set by the Commission, and eight members who are nonproviders. Nonproviders are selected in the following manner: two are to be selected from recommendations made by statewide labor organizations (with one of the two recommended by the State Labor Council, AFL-CIO) and two are to be selected from recommendations made by statewide organizations representing interests of the elderly. The sixteen provider and nonprovider members are appointed by the Commission for three-year terms.

[2]Emergency regulations fall under the purview of the state's general laws.

[3]Chapter 409 of the Acts of 1976.

the Executive Office of Human Services; the remaining nine are appointed by the Governor. According to the law, the nine appointments must include: two chosen from a list of six recommendations submitted by the Massachusetts Hospital Association, one representing teaching hospitals and one representing nonteaching hospitals; one physician from a list of three names submitted by the Massachusetts Medical Society; one nonprovider board member of a health systems agency; one representative of Blue Cross; one representative of commercial insurance companies; and three nonprovider members representing business, labor, and the elderly, respectively, each with experience in or knowledge of the delivery of health care or the financing of hospitals.

The Commissioner of Public Health and the director of the state Medicaid program were the two appointees from the Executive Office of the Secretary of Human Services. The latter two appointees tend to weight the Board more heavily against the hospital industry. One of the functions of the Department of Public Health and the Department of Public Welfare is to be a "watchdog over the industry." The Commissioner of Public Health was an outspoken critic of the hospital industry; the director of the Medicaid division is naturally concerned about the costs of the Medicaid program and views the hospitals an an opposing force in cost containment.

The impact of the Board in the rate-setting process, as well as key influences on the Board, will be discussed in detail in the preliminary assessment section. It is appropriate to note at this point that the Board as currently conceived does not establish policy directives for the Commission; rather, it reacts to policies proposed by the Commission and assists in refining that which is proposed.

Consultation

Another mechanism designed to ensure industry input into the rate-setting process is that of mandatory consultation. The Rate Setting Commission is required to "consult with representatives of Blue Cross of Massachusetts, the Massachusetts Hospital Association, commercial insurance carriers and the health systems agencies" in the development of new methodologies.[1]

Bureau of Hospitals: Organization and Responsibility

The Commission has a staff of approximately 120, half of whom work in the Bureau of Hospitals. With the exception of the bureau director and the federal project staff, the majority of the staff are accountants. Figure 7 shows the organization of the Hospital Bureau. In addition to managing the

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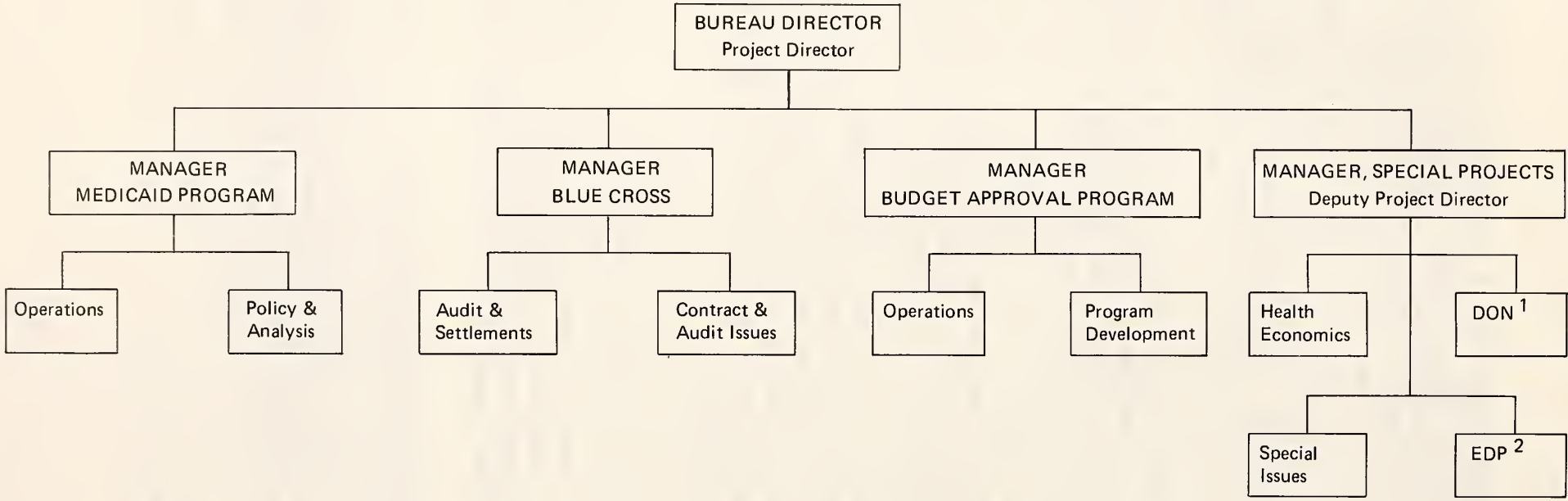
[1]Massachusetts General Laws, C.6A, S.37.

Figure 7
ORGANIZATION OF THE BUREAU OF HOSPITALS



Source: Massachusetts Rate Setting Commission

[1]Determination of Need Program

[2]Data Processing Department

409 and Medicaid programs, the Bureau's major responsibilities have traditionally included:

- the review and approval of contracts between Blue Cross of Massachusetts, Inc. and hospitals, and the approval of rates developed under such contracts;

- the performance of all hospital audits required in establishing public assistance rates and the preparation of Blue Cross final settlements;

- the performance of financial analyses on major hospital applications for determination of need approval as requested by the Department of Public Health;

- the calculation of an estimate of the expected revenue for the City of Boston, Department of Health and Hospitals (the revenue projection is required by law to be used in the calculation by the City of its annual tax rate);[1] and

- the establishment of Industrial Accident Rates.

The Bureau director is responsible for the day-to-day management of the Bureau and reports directly to the commissioners. The Medicaid system and the charge control program each have program managers. With the award of the federal grant in 1976, the Bureau staff was also considerably upgraded. At present, however, the Bureau is in a state of transition, and it is useful at this point to consider why this situation has arisen.

The current state of transition within the Commission appears to have been precipitated by several factors. First, two commissioners left during the spring of year 1979: the chairman and the commissioner representing the "medical economist." The "medical economist" slot was filled by an individual with a strong program management and administrative background. The chairman's position was just recently filled by an attorney with regulatory experience.

The chairman's term, however, was up for reappointment in June 1979. The CPA commissioner is also up for reappointment in two years. Of course, at present, no one knows whether the newly elected Governor will prefer to appoint his own representatives to the Commission.

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[1]Massachusetts Rate Setting Commission, Annual Report, 1977.

A number of key staff within the Bureau of Hospitals, including the federal project director and the manager of the 409 program, also left during the fall of 1978. The most recent departure, however, was that of the Bureau director. The program Bureau director, a highly respected and well-liked individual, also departed during this period.

The turnover in the commissioners and Bureau staff has taken place at a crucial time in the Commission's history. While some consider the Commission to be firmly entrenched as a regulatory agency, subsequent sections of the case study suggest that both the authority and viability of the Commission will be subject to significant challenges within the next three years. The Commission, in 1979 (FY 1980), will be implementing one of the more controversial aspects of the 409 program--groupings and cost comparisons. The Medicaid program is also likely to be the target for additional cutbacks from the state. Thus, far from entering into a period of relative quietude, both situations suggest the need for strong leadership that is capable of effective negotiation with the hospital industry. Furthermore, staff with strong analytic and technical skills to justify the results of the research being conducted will be needed.[1]

EVOLUTION OF CHARGE CONTROL SYSTEM (CHAPTERS 424 AND 409)

Overview

Massachusetts hospitals have been under a combined charge control/ budget review system for four years. From 1975 through 1976, hospitals proposing to modify charges or implement new charges were required to submit budgets to the Commission for approval. By 1977 (FY 1978), all hospital budgets were subject to review by the Commission. During the first three years, a budget was approved if the hospital maintained a ratio of allowable costs to charges of ninety-five percent (or the ratio year ratio) and limited year-to-year increases. The major objective of the charge control system during the first three years was twofold:

- to slow the rate of increase in hospital charges; and
- to prevent major disturbance of the system while a permanent cost and revenue control program was being developed and implemented.

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[1]The Commission has since hired a new Bureau director who brings a strong background in health care financing and health planning.

The year 1978 (FY 1979) brought the most extensive changes to the 409 program. The Commission moved from approving a cost-to-charge ratio to approving net patient service revenue and charges as they generate the appropriate amount of revenue. The most extensive changes to the system, however, are slated for 1979 (FY 1980), including the use of hospital groupings and cost comparisons among hospitals. Figure 8 summarizes major changes that have occurred (or are projected) in the system since it was implemented.

1975: Chapter 424 (FY 1976)[1]

The methodology used during this first year of charge regulation was a combined review of budget and charges. Chapter 424 required that only hospitals proposing charge modification or implementation of new charges submit to the Commission. The requirement applied to:

- charges implemented between the date of the Governor's freeze proposal (April) and the end of the 1975 fiscal year (September 30);
- charges proposed for the hospital's 1976 fiscal year (beginning October 1, 1975) and for subsequent charges; and
- charges for new services.

Throughout FY 1976, 123 hospitals filed charge submissions at least once. Twenty-eight submitted a second application for an additional charge modification, and only one hospital filed for a third review.[2]

There are four salient characteristics of the statutory provisions in effect in FY 1976:

- The primary criteria for approval was the allowability of underlying cost increases and the ratio of total patient care cost to net patient care revenue. The ratio of cost to charges was kept at a minimum of ninety-five percent unless the hospital had enjoyed a lower ratio year ratio.
- Net patient care revenue excluded publicly aided contractual adjustments and revenue generated by private room differentials.

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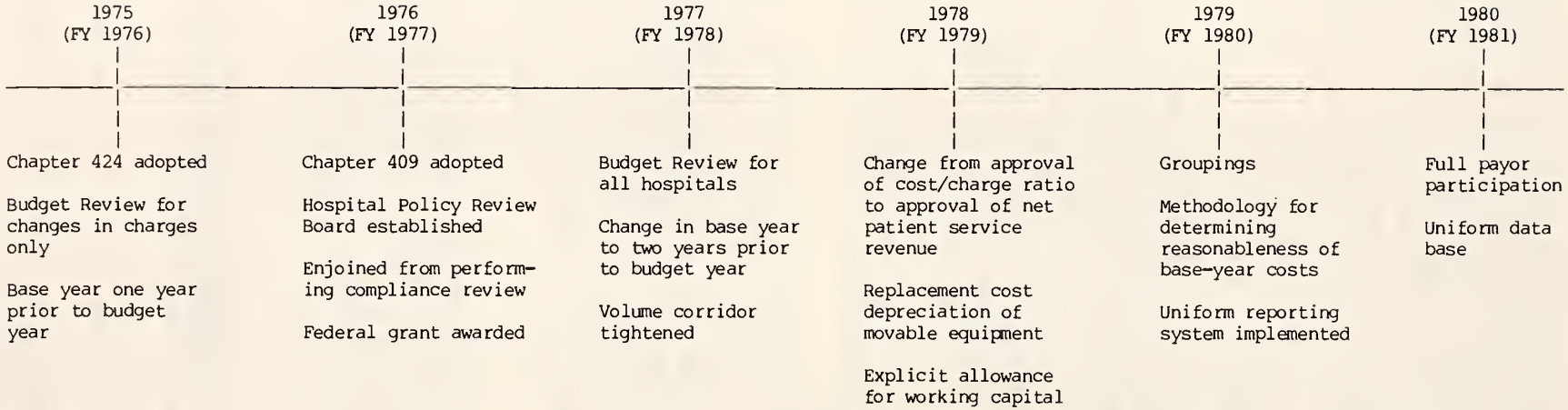
[1]The information in this section is taken extensively from MRSC Proposal No. SSA-76-0127, 1976.

[2]W. Grieco, "Note on Hospital Charge Control in Massachusetts," Harvard School of Public Health, 1978.

FIGURE 8: Evolution of Budget Review/Charge Control System


1975 (FY 1976)
Chapter 424 adopted
Budget Review for changes in charges only
Base year one year prior to budget year
1976 (FY 1977)
Chapter 409 adopted
Hospital Policy Review Board established
Enjoined from performing compliance review
Federal grant awarded
1977 (FY 1978)
Budget Review for all hospitals
Change in base year to two years prior to budget year
Volume corridor tightened
1978 (FY 1979)
Change from approval of cost/charge ratio to approval of net patient service revenue
Replacement cost depreciation of movable equipment
Explicit allowance for working capital
1979 (FY 1980)
Groupings
Methodology for determining reasonableness of base-year costs
Uniform reporting system implemented
1980 (FY 1981)
Full payor participation
Uniform data base

- Total patient care costs were computed using Medicare cost definitions but added the actual cost of bad debt and free care to allowable costs.[1]

- New service charges were treated separately.

During FY 1976, Medicare cost definitions were used. Thus, all direct and indirect costs related to direct patient care were included in the definition; excluded from the definition were all research-related expenses and recovered expenses, i.e., those which are offset by revenue. Depreciation was computed on a historical cost, straight-line basis unless the hospital was allowed to use an accelerated method under Medicare. Additional costs included were interest expense, rental and lease expense, and bad debt and free care.

The ratio year, specified by statute, was designated as the period from April 1, 1974 to March 31, 1975. The 1975 fiscal year provided the base-year cost for FY 1976.[2] This was then adjusted to compute the hospital's FY 1976 allowable cost.[3]

Hospitals that requested an increase in charges for FY 1976 were required to submit eight months' actual and four months' projected data for the base year. For fiscal year 1976, the Commission did not make any adjustments to the base-year actual costs, with the exception of eliminating the direct cost associated with a discontinued service. Hospitals were informed, however, that in subsequent fiscal years, the base-year costs submitted would be compared with the amount budgeted and approved for the year. That is, the Commission planned on conducting some form of compliance review. As will be explained later, the Commission has been enjoined from collecting any excess revenue from hospitals.

Screens

Base-year costs were subjected to three screens: inflation, volume, and costs beyond the control of the hospital.[4] The screens have not changed significantly over the years, although they have undergone some revisions. Each screen is briefly described in turn.

Inflation. During this first year of rate regulation, a composite inflation index developed by a Boston-based consulting firm for Blue Cross

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[1]Limitations on the amount of cost were also incorporated.

[2]Most hospital fiscal years run from October 1 through September 30.

[3]This time frame represented the first full twelve months after implementation of the Economic Stabilization Program.

[4]Inflation, volume, and costs beyond the control of the hospital are also referred to as "adjustments."

and the MHA was used. There were two salient characteristics of the original inflation methodology: external indicators were used in order to keep the rate of inflation in the hospital industry generally down to the level experienced in the economy; in addition, the methodology did not recognize any local or regional factors that would have an impact on inflation rates. The latter, especially, has been a source of much concern over the past four years and has been revised for FY 1979. The inflation factor applied to each hospital is unique, however, in that it is based on the costs of the individual hospital.

Volume Adjustment. Hospitals were required to submit volume projections for each revenue-generating department. The Commission then applied a test of reasonableness: base-year allowable costs were adjusted for inflation and volume corridors were applied. In FY 1976, acceptable volume corridors were those that fell within an annual five percent increase or ten percent decrease. For each unit of increase (decrease) beyond the corridors, forty percent of base-year unit costs adjusted for inflation was allowed.

Costs Beyond Control of the Hospital (CBC). Costs beyond the hospital's control were and still are strictly defined by Commission regulation. These are as follows:

- costs generated by government requirements;
- costs generated by capital expenditures or changes in service approved by the Department of Public Health under the Commonwealth's Determination of Need Program;
- costs generated by increased insurance premiums or by self-insurance; and
- costs not recognized under Chapter 409 that impose financial hardship on the hospital.

Adjustments for costs beyond the hospital's control represented one of the few areas where negotiation might enter into the budget review process. Because of the specific documentation required by regulation for a CBC, negotiation was extremely limited. A separate adjustment was also done for "physician billing" to account for changes in hospital cost and revenue that arose from changes in the salaries of hospital-based physicians.

New Services. A separate ratio was established and tested for charges associated with a new service. A new service for FY 1976 was defined as a service that had $50,000 annually of cost and/or had generated $50,000 of revenue and represented a new charge for the hospital. The projected

operating costs (both direct and indirect) of a new capital outlay associated with a new service were treated separately from the total budget. That is, these costs were eliminated from the total budget-year figure that was compared to the base. In essence, the operating cost associated with a new service was a pass-through cost. As will be seen later, this practice changed in FY 1979.

Interim Adjustments. A hospital was allowed two interim submissions during the budget year, which allowed a hospital to modify its volume projections and its charges on the basis of the resultant change in aggregate allowable revenue. Basically, the Commission considered all requests for changes in charges to be submissions, except in the following cases:

- changes associated with transfers of cost; and
- adjustment of various charges to more closely approximate underlying cost, without changing aggregate revenue.

Chapter 409 of the Acts of 1976

The transition from 424 to 409 did not precipitate any dramatic changes in large part because Chapter 409 was a repromulgation of Chapter 424. Changes in the methodology that were included in the law were linked to a specific timetable. The law mandated the development of a grouping methodology and allowed three years for its implementation. The law also gave the Commission the power to develop and implement a reporting system, again in a phased-in manner, since the system could only be used by the Commission in conjunction with the grouping methodology. Chapter 409 also specified that all hospitals would have to submit budgets for FY 1978 (1977) for review by the Commission.

The most significant change in the system was scheduled for implementation in 1978 (FY 1979). At this time, the Commission was to move from the approval of a cost-to-charge ratio to approval of the reasonable financial requirements of hospitals. Another change introduced with the adoption of Chapter 409 was the formation of a Hospital Policy Review Board, whose intended role was to keep the regulations sensitive to the needs of appropriate interest groups. Members of the Board represent hospitals, physicians, HSAs, Blue Cross and commercial health insurors, and nonproviders who are to "represent the interests of business, labor and the elderly." The Board is empowered to review and comment on all regulations proposed by the Commission and may call a public hearing on a regulation they have recommended for disapproval.

The regulations promulgated by the Commission for FY 1977 included two additional changes to be implemented that year. The first change was related to the establishment of substantive standards to be used for setting new charges, while the second alteration concerned the Commission's authority to conduct compliance review. The Commission, under Section 38 of Chapter 409, has the power to "issue regulations setting forth the procedure and substantive standards to be applied in reviewing an application for new charges." Regulations for FY 1977 included standards for new CAT scanner services. To date, this is the only service for which substantive standards exist.

Compliance--the manner in which the recovery of excess revenue will be enforced--was another important issue considered in that year. Compliance review has had a confusing history. Several plans were considered by the Commission. The first plan mandated that excess revenue earned in FY 1976 would be applied against 1977 revenues. The second plan went to the opposite extreme, replacing the terms of recovery in 1977 with recovery in "future years." The final plan that was eventually put into effect was a compromise proposing that fifty percent of excess revenues earned in 1976 be recovered in FY 1977. The Commission saw this method as one that would balance the public policy goal of allowing consumers to realize savings through justifiably decreased charges without adversely affecting the financial viability of the individual hospital. The methodology also allowed the hospitals themselves to comply by budgeting a cushion, thereby spreading the required recovery over an entire fiscal year. As will be described in the section on legal challenges to the system, compliance became a moot issue in 1977 when, as a result of Affiliated Hospital Center, Inc. v. Weiner (et al.), the Commission was prevented from implementing compliance review. The court ruled that compliance review was a retrospective mechanism inconsistent with the philosophy of the prospective system as defined in Chapter 409.

In summary, the transition year introduced little change in the methodology used by the Commission. The permanent legislation brought more specificity and detail to the original law. It underlined certain provisions by either acting upon them, as in the case of setting the standards for the new CAT scanner services, or by designing a system for enforcement of a regulation, as in the case of compliance.

1977 (FY 1978)

The year 1977 brought changes in the 409 system, as a result of both mandates of the law and challenges to the law. In carrying out the mandate of Chapter 409, all hospital budgets were now subject to review, including those of psychiatric hospitals. Moreover, as part of a joint project with the Office of Health Planning and Development, hospitals were required to submit one-year and five-year plans. Another change during this year was a

decrease in the volume corridors; full-cost coverage of volume increases was limited to three percent, while volume decreases were limited to five percent.

The most important change in the methodology that occurred in FY 1978, however, was the change from the base year of the preceding year to the rate year prior to that year; described below in more detail, this basically represents a change from a one-year-old to a two-year-old base,[1] a direct result of the court decision rendered against compliance in Affiliated Hospital Center, Inc. v. Weiner. The benefit to the Commission in using a two-year-old base is clear in that it improved the degree of accuracy of base-year data, and thus of the rate year, since this is projected through a roll-forward mechanism applied to the base. Actual costs and actual inflation rates exist for the two-year-old base year, whereas the one-year-old base consisted of a projection upon a projection. Although eight months of actual cost data were available, the remaining four months were projected; the inflation rate was projected for the entire twelve-month period.

The method is more thoroughly described in the section on the 409 budget review process; briefly captioned here, it follows this formula. The base-year costs are adjusted for inflation, volume, costs beyond control, new services, and transfers of cost and are compared to the intermediate year of eight months' actual data and four months' projected data. The lower of the base year adjusted or the intermediate year projected is adjusted once again for inflation, volume, and CBCs and compared to the rate-year budgeted costs. The lower of rolled-forward base or requested budget-year costs is approved, still using a ninety-five percent cost-to-charge ratio. The change in the base year, which was a last-minute change promulgated through emergency regulation, precipitated another round of controversy. The Commission's authority to use the two-year base was challenged in court. In Affiliated Hospital Center, Inc. v. Weiner, the Affiliated Hospital Center charged that the change in the base year was effectively compliance disguised by another name. This time the Commission prevailed, however, and the two-year-old base year became a permanent part of the methodology.

1978 (FY 1979)

The Commission's mandate for 1978 is contained in Section 5 of Chapter 409:

> . . . the Rate Setting Commission shall develop and adopt a definition of "total patient care charges" which shall reflect actual revenue received by each hospital

[1]With this change, hospitals were required to submit three years of data rather than two.

> for all patient care services, supplies and accommodations and a definition of "total patient care costs" which shall reflect the reasonable financial requirements of each hospital for providing patient care services, supplies and accommodations.

What this meant for 1978 (FY 1979) was that the Commission moved from a charge approval system, based on approval of a ratio of cost to charges, to one of approving net patient service revenue and charges as they generate the appropriate amount of revenue. Revenue is defined as actual charges to patients and third-party payors exclusive of bad debt, free care, and contractual adjustments. Costs are defined as the reasonable financial requirements of each hospital for providing such patient care. Reasonable financial requirements are comprised of three elements--the Operating Requirement, the Capital Requirement, and the Working Capital Requirement.

Having detailed the methodology that has been in operation during the first four years of the 424/409 system, the discussion turns in the next section to the concepts and methodology introduced in 1978 and the mechanics of the budget review process.

409 Budget Review Process

With the methodological change in 1978 from the approval of a cost-to-charge ratio to approval of net patient service revenue, revisions in the actual process used by the budget analyst were initiated. Furthermore, the voluminous package of forms submitted by the hospitals was unfamiliar to most analysts. The data to be submitted by the hospital are described in Table 1.

To more effectively allocate staff resources, the Bureau of Hospitals instituted this year a prescreening process administered by five of the senior audit staff (referencers). The prescreen checked to see that the form was complete, that supporting data were included where appropriate, and whether inflation, working capital, and depreciation were calculated correctly. The package was then sent to an audit analyst. The three items that comprise reasonable financial requirements--Operating Requirement, the Capital Requirement, and the Working Capital Requirement--are analyzed separately.

The Operating Requirement

Definition. The definition of operating requirement did not substantially change from that used in past years. The definition remained as the "allowed cost for hospital care services, supplies and accommodations, which includes the direct operating cost of service producing areas and the overhead cost allocated to the service producing areas through the stepdown. . ." A change made for fiscal 1979, however, was that new services

TABLE 1: Description of Data Required for 1978 (FY 79) Budget Review

SECTION A - Summary Schedules

These are used for the calculation of maximum gross revenue. Data are given on new service deficits, patient mix, income from cost-based reimbursers for both inpatient and outpatient services, provision for bad debt and free care, and patient days segregated by service.

SECTION B - Revenue Schedules

Data are given on patient operating and nonoperating, nonpatient operating and nonoperating revenue; and also routine patient revenue segregated by service for the base, intermediate, and rate years.

SECTION C - Hospital Financial Schedules

This was to include balance sheets on restricted and unrestricted funds and Statements of Change in Financial Position, and was to be used by the Commission for information. The reporting methods used by the hospitals in this area were so diverse that no comparison between hospitals was possible, and so the information was almost useless.

SECTION D - Working Capital Budget Schedules

The percentage increase in needs from intermediate to budget year is calculated and data are given on the composition of accounts receivable in both years.

SECTION E - Capital Budget Schedules

These provide data on building and fixed equipment segregated by hospital, nonhospital, patient, and nonpatient properties; patient care building and fixed equipment depreciation for the base, intermediate, and rate years; patient and nonpatient interest; replacement value depreciation on major movable equipment; and the capital requirement for Determination of Need projects.

SECTION F - Operating Budget Summary

These forms are used to facilitate the comparison of base to intermediate to budget year operating costs to determine maximum allowable operating costs.

SECTIONS G, H and I - Operating Cost Schedules

Contains data for the base, intermediate, and budget years by cost center on overhead and patient care direct costs, statistics, and stepdown cost.

TABLE 1 (continued)

SECTION J - Inflation Adjustment Schedules

The composite inflation index is calculated for the base and intermediate years to arrive at inflated operating costs and volume adjustments.

SECTION K - Volume adjustment schedules

Data are given by cost center.

SECTION L - Costs Beyond Control Adjustment Schedules

Costs beyond the control of the hospital are allowable costs in the operating budget, which, as one of the "screens," justifies the budget-year costs beyond inflation and volume. Thorough documentation of such costs is required. Data must be given justifying that costs have not been included under allowed cost or volume adjustment, that the costs fall under five specific categories. Recurring and nonrecurring elements of the costs beyond control must be identified.

SECTION M - Determination of Need Schedules

These must be included only if a project will become operational within six months of the filing date.

SECTION N - Supplementary Schedules

Various information including activity and salary information on physicians employed by the hospital. Hospitals showed some reluctance to give these data, although the Commission stated that they were to be used to provide information only.

SECTION O - New Service Schedules

Information concerning a new service and the identification of any new service deficit that is deducted from gross patient revenue are provided in this section. Background information, cost, volume, and revenue data are given.

SECTION Q - Transfer of Cost Schedules

Transfers "on" and "off" that have occurred from the base to the budget years are identified--to be added or subtracted from those years in calculation of the formula for maximum allowable operating costs.

were to be defined as new cost centers according to HURM (Hospital Uniform Reporting Manual) and evaluated separately. The purpose of this requirement is to eliminate cross-subsidization of new service deficits, defined as the difference between the reasonable financial requirements and the net patient service revenue able to be generated by the new service. FY 1979 regulations allow a 100 percent subsidy of the deficit in the first year of operations and 50 percent in the second year. Subsequent to that, the hospital must absorb the deficit completely since it is subtracted from gross patient service revenue.

Another change in the calculation of the operating requirement is in the treatment of bad debt and free care. The actual write-off was replaced by the provision for bad debt and free care and calculated as a percentage of gross patient service revenues (GPSR). The reasonability standard applied was that the provision as a percentage of GSPR for the budget year not exceed the average of the provision calculated for the intermediate years. Thus, bad debt and free care were not treated as a cost, but rather as a deduction from revenue.

Screens. The same three screens--volume, inflation, and costs beyond control--were used this year. However, the latter two have undergone revision. The inflation index has been the subject of dispute between the hospital industry and the Commission. Research conducted under the Commission's federal contract in FY 1978 resulted in some compromise changes in the index for FY 1979. As in prior years, the inflation index is a composite one and is unique to each hospital in that it is weighted according to each hospital's cost structure.[1] The original twenty cost categories were reduced to sixteen by the elimination of bad debt, free care, depreciation, and interest (see Appendix A). These categories are now grouped according to salaries and fringe benefits, supplies, utilities, purchased services, leased equipment, and others. Six criteria were established in the selection of the categories, as follows:

- significance as a proportion of total cost,
- compatibility with current hospital accounting practices,
- availability of appropriate associated indicators,

[1]The difference in trend factors among the hospitals is not considered significant. For FY 1978, the variance was between 7.1 percent and 7.3 percent.

- diversity,
- homogeneity of included costs, and
- inclusiveness.

Each category is paired with an economic change indicator, selected on the basis of five criteria:

- correspondence to cost category,
- frequency of publication,
- validity of the data,
- neutrality, and
- localization of the indicator to the factor market area of the hospital.

The last criterion, implemented in nine of the sixteen categories, would be considered a gain for the hospitals who had been arguing for the use of local indicators for a long time. However, the indicators are still--except in the case of leased equipment--external to the hospital industry. Although a source of discontent among the hospitals, the use of external indicators is not likely to change, since it is an integral part of the 409 statute.

For the intermediate year, the projected inflation values are determined through a projection equation that has been developed for twelve of the indicators; the other four are projected using what the Commission descibes as "ad hoc techniques." Where necessary, adjustment factors are added to the equations to account for actual and/or expected differences between the levels of the actual and projected series.

Using the Harbridge House technique, the Commission developed a separate index for the intermediate year and the budget year. The inflation factors for the intermediate year are based on both actual data and projections, while the budget-year index is forecasted.

Recall that in past years volume was calculated for the budget year for each revenue-generating department. The method of calculating volume remained the same this year as did the reasonability tests applied. The assumptions underlying the tests for reasonability are:

- inpatient days and outpatient visits can be expected to vary independently within a certain range and

- volume in ancillary deparments would be expected to vary in relationship to variations in patient days and outpatient visits. The exact relationship can be predicted by a hospital's historical experience.

Base-year allowable unit costs are adjusted for inflation and volume corridors are applied. Volume corridors remained the same this year; thus, volume changes falling within a three percent annual increase or five percent annual decrease were considered acceptable. For each unit of increase (decrease) beyond the corridors, forty percent of base-year unit costs adjusted for inflation is allowed. The allowed previous year cost per service unit, adjusted for inflation, is multiplied by the allowable volume change in order to compute an allowable volume adjustment by department. The total of all department volume adjustments is the total volume adjustment.

The adjustment for costs beyond the hospital's control have been made more stringent in FY 1979 to reflect a strict interpretation of "beyond the hospital's control." The Commission excluded depreciation, interest, and working capital associated with a determination of need (DON) project.[1] If requesting a determination of need CBC, the operating costs of such a project must be documented on new determination of need CBC schedules, segregated by cost center. Furthermore, volume adjustments on DONs considered a CBC were not allowed. In essence the hospital has the option to take the DON costs either through a CBC or through a volume adjustment, but not both.

Determination of the Operating Requirement

The operating cost requirement represents the most time-consuming portion of the analysis. Data are taken from twelve of the fifteen sections described in Table 1, and consistency checks are made to assure that cost centers designated in the volume adjustment section are the same as those in the operating cost sections. The analyst further verifies that there is no duplication of determination of need pass-through costs and volume adjustments; that transfers of cost and new and discontinued services are handled properly; and that nonpatient areas have been assigned overhead appropriately. After these items have been verified, the formula of the operating requirement is then applied as shown in Table 2.

The Capital Requirement

Definition of Capital Requirements. The only change made in the handling of capital items for FY 1979 was the replacement of historical cost depreciation with price-level depreciation on major movable equipment.[2]

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[1]These costs are essentially pass-throughs in the capital budget.

[2]Recall that the capital requirement itself is new.

TABLE 2: Operating Requirement Formula

STEP 1:

ADJUSTED BASE-YEAR COSTS are determined by subtracting the costs of:

Building and fixed equipment Long-term interest Major movable equipment depreciation	]]]]	moved to the capital budget
New service operating costs	-	evaluated separately
Discontinued services Transfers "off" of cost	]]	subtracted to make all years comparable

and adding:

Transfers "on" of cost	-	added to make all years comparable

the product equals: ADJUSTED BASE-YEAR OPERATING COSTS

plus: inflation adjustment
volume adjustment
costs beyond control adjustment

STEP 2:

MAXIMUM ALLOWABLE ADJUSTED INTERMEDIATE-YEAR OPERATING COST equals:

the lower of: INTERMEDIATE-YEAR OPERATING COST

or: MAXIMUM ALLOWABLE ADJUSTED INTERMEDIATE-YEAR OPERATING COST

less: discontinued services
transfer "off" of costs

plus: transfer "on" of costs

the product equals: ADJUSTED INTERMEDIATE-YEAR OPERATING COST

plus: inflation adjustment
volume adjustment
costs beyond control adjustment

STEP 3:

MAXIMUM ALLOWABLE ADJUSTED BUDGET-YEAR OPERATING COST equals:

the lower of: BUDGET-YEAR OPERATING COST

or: MAXIMUM ALLOWABLE ADJUSTED COST (by adding and subtracting the same items given above)

STEP 4:

THE OPERATING REQUIREMENT equals:

BUDGET-YEAR OPERATING COST

plus: any new service MAXIMUM OPERATING COST

Source: Massachusetts Rate Setting Commission, Contract No. 600-76-0174, September 1978.

Allowed capital cost remained the sum of the allowed cost for depreciation or replacement value on building and fixed equipment, plus price-level depreciation in major movable equipment, plus interest expense on capital expenses. A return on investment for proprietary hospitals is also allowed. An interesting footnote, which has ominous implications for the hospitals is that FY 1979 regulations state that hospitals may, in the future, have to offset capital costs by applying nonoperating revenues to these costs. This has prompted the MHA to file legislation that would amend Chapter 409 to limit the Commission's authority to tap other and nonoperating funds.

Determination of Capital Budget Requirement. Section E of Table 1 contained the data for determination of the capital budget requirement. This is the most precise analysis within the entire procedure. The analyst verifies that the items of building and fixed equipment, interest, and depreciation have been correctly transferred from the operating sections, where they have been subtracted to determine operating requirements. Checks are also made to determine that nonpatient items have been excluded and that replacement value depreciation has been properly calculated on major movable equipment. Verification of the reasonableness of the basis used in determining the depreciation is also done, but on an informal basis.

The Working Capital Requirement

Definition of the Working Capital Requirement. In line with defining reasonable financial requirements, the Commission included an allowance for working capital.[1] The concept provoked considerable controversy, which arose in part because of problems in the actual calculation, and in part because of the use of emergency regulation to again introduce last-minute change. The working capital requirement was defined as the intermediate year net patient accounts receivable times the increase in need. The Commission first proposed that the calculation of the net receivables include all payors according to the following number of allowed days in receivables:

Payor	Inpatient	Outpatient
Blue Cross	40	90
Medicare	40	100
Medicaid	200	120
Commercial	100	200
Self-Payors	365	200

[1]Recognition of a working capital requirement is consistent with AHA's statement on financial requirements of hospitals.

However, use of that formula resulted in what has been described as "inordinate rate increases," which provoked considerable uproar among such key members of the Hospital Policy Review Board as Blue Cross, the Department of Public Health, and the Department of Public Welfare. As a result, the Commission limited allowable days in receivables to charge-based payors. The reason offered to hospitals for making the change was that the method of providing working capital is dissimilar among the various classes of payors. The Commission, in its public testimony on the matter, basically admitted that it had not been aware of the fact that Blue Cross and Medicare provide hospitals with current financing to cover working capital needs. Specifically, Blue Cross assists hospitals in providing working capital needs through a draft system, current financing, and payment for interest on short-term borrowing. Medicare also offers a method for financing of working capital through the Periodic Interim Payment System. Medicaid was also initially excluded, but this was reconsidered, and through an amendment to the regulations retroactive to the beginning of the fiscal year, an allowance for Medicaid receivables was included in the calculation of an allowable working capital requirement.

Determination of the Working Capital Requirement. The last step of the analysis concerns the working capital requirement. Originally, the 1978 average net (of bad debt and contractual accounts receivable) was to be used to calculate the working capital requirement. However, for hospitals that did not keep records in this way, year-end net receivables were also accepted. Although data were taken on 1978 receivables, 1977 data were requested also, primarily to determine the reasonableness of the 1978 data. The soundness of the allowance for bad debt is verified by data supplied in Section A (refer to Table 1). Both of the reasonability tests applied merely insure that there has not been an unjustified significant change from the 1978 eight months' actual and four months' projected receivables to 1979 projected receivables--and that 1978 receivables are somewhat representative of those for 1977.

The calculation of the percentage increase in need is checked against the operating schedules to assure that the appropriate figures have been transferred to the working capital section. The percentage increase in need is defined as the quotient of the lower of allowable budget-year operating and capital costs over the intermediate-year budgeted capital and operating costs. As discussed earlier, this method allows a much more conservative increase, since the intermediate-year budgeted cost is usually higher than the allowable cost. The analyst makes one final check to determine that the appropriate number of days by payor class has been used to calculate the working capital requirement. Because hospitals are not uniform in their accounting of receivables, the analyst also checks for consistency of reporting of coinsurance receivables and verifies that revenues and receivables are being reported consistently. The working capital requirement is then calculated as:

AVERAGE NET PATIENT ACCOUNTS RECEIVABLE
times THE PERCENTAGE INCREASE IN NEED

The data on the summary sheet may now be verified. The analyst checks the schedules that contain the data for estimating cost-based reimbursement. The figures used by the hospital are checked against the rates for Medicaid and the preliminary Blue Cross settlements, which are on file at the Commission. The patient mix is verified to assure that it is based correctly on the revenue generated by each payor class for three years. The working capital requirement, capital requirement, and operating requirement are summed to produce reasonable financial requirements. Cost-based payor reimbursement is deducted, leaving the portion of reasonable financial requirements to be met by charge-based payors.

This figure is further adjusted by determining the amount of revenue the hospital would need to generate if 100 percent of its patient mix were charge based. This is equal to Gross Maximum Patient Service Revenue (GPSR). This figure is compared to Requested Gross Patient Service Revenue (charges) and the lower amount becomes Allowed Gross Patient Service Revenue. The analyst subtracts contractual adjustments and the provision for bad debt and free care to produce Net Patient Service Revenue, which is synonymous with total patient charges. The line item approved is Total Patient Care Charges. Recall that Chapter 409 is considered a charge approval system. Thus, hospitals are required to submit a charge book reconciliation, which indicates the way the hospital will generate the allowable patient service revenue approved by the Commission. If the hospital is merely increasing prices across the board by a certain percentage, this does not present a significant problem. However, as evidenced by the poor quality of the charge control reconciliation books submitted in fiscal year 1979, hospitals changing individual prices within departments are faced with a considerable accounting task.

Finally, if a new service deficit exists, the appropriate percentage is deducted from Gross Patient Service Revenue. Recall that the system allows total cross-subsidization of new service deficits in the first year of operation of the new service and fifty percent in the second year. After that, the hospital must absorb the loss elsewhere. In FY 1979, the definition of new services included cost centers under HURM that began operation on October 1, 1975. Data were required on expected income, sources of income, and expenses. The new service "reasonability of costs" is analyzed separately early in the process, but the costs are folded back into total financial requirements.

In summary, 1978 (FY 1979) introduced the most significant changes in the methodologies and review process used in the 409 program. During this year, new controversies emerged, legal challenges were lodged, legislative amendments were proposed, and both staff and commissioners resigned and were replaced. A preliminary assessment of the impact of these changes is offered in the section on preliminary assessment.

Medicaid System

Overview

Massachusetts instituted its prospective system for Medicaid reimbursement in 1974. Unchanged since its inception, the program was designed to curtail the spiraling Medicaid budget. The original program proposed by the Commission was modeled after the New York system and was far more sophisticated than the one subsequently approved by the Social Security Administration and adopted by Massachusetts. The methodology originally proposed would have established an inpatient per diem rate for each hospital, based on a two-year cost experience, adjusted for inflation. The proposal also contained a provision for comparison of per diem rates across hospitals through a grouping mechanism. Ten groups of hospitals were to be established according to location, base-year patient days, level of teaching activity, and ownership. The grouping mechanism was not approved, however, and only the two distinctions of teaching and nonteaching hospitals remain. The two distinctions are made only when determining appropriate occupancy levels. The original proposal also had a ceiling on cost of stay, but because implementation of this was dependent upon the grouping mechanism, it did not become a part of the final plan.

The current system employs inflation indices common to like categories in the economy, and occupancy floors are used to penalize hospitals for underutilization. The occupancy standards used in the first year are presented below.

Occupancy Standards

Department	Percent Teaching	Percent Nonteaching
Maternity	60	60
Medical/Surgical	80	75

Furthermore, the system, unlike 409, provides for the verification of the base-year costs used in the calculation of the Medicaid per diem rate through the use of audited data. Another stringent aspect of the system empowers the Commission to review a rate that was based on unaudited data when audited data become available--and to change that rate, if warranted. In comparison to the 409 system, the formula approach of the Medicaid system is rather simplistic. The Medicaid system is also more stringent than 409 in that it must respond to the pressures to restrain the growth of the Medicaid budget.

Evolution of the Medicaid System. The prospective system came into effect during the last few months of FY 1974. Fiscal 1975 (1974), then, was the first complete year in which hospitals were regulated under the prospective system. An inpatient per diem rate was established for each hospital for maternity and nonmaternity inpatient days by dividing the provider's reimbursable rate-year inpatient operating costs and reimbursable inpatient nonoperating costs by the allowable inpatient days. As mentioned, cost was determined on a two-year-old base year and rolled forward to adjust for two years of inflation.

Outpatient rates were determined by computing the ratio of the provider's total reimbursable outpatient operating costs and nonoperating costs for the base year to the provider's total operating allowable charges for outpatient services during the base year. The resultant percentage was applied to the provider's billed charges to Medicaid recipients in the rate year. Costs could not exceed 100 percent of charges. The only negotiable aspect of the system was and still is the Administrative Adjustment section of the regulations, which details those circumstances under which a hospital may request a change in the per diem rate. The Commission is required to act upon such a request within sixty days.

In FY 1976 (1975), the second year of the system, two changes occurred. The original reporting form was replaced by the more sophisticated RSC-401, which is still being used today.[1] Another change was the severe cutback in Medicaid coverage, which was instituted in response to the serious financial problems that beset the program during its first year of operation as a prospective system. As a result, some 28,000 general relief recipients were totally eliminated from almost all coverage. Moreover, several medical and social services were cut for those covered under the Medicaid program, although most of these were reinstated during FY 1977.

During 1977, the state continued work on further refinements to the Medicaid methodology. The impetus for this, besides the obvious need for cost containment, was a court decision rendered against the 409 program, which enjoined the Commission from instituting compliance. Sensitive to the decision against compliance and its possible implications for the Medicaid system, the Medicaid system placed a limit on recognition of base-year cost. The limit was the costs of the year prior to the base year, adjusted for one year of actual inflation. Recall that the methodology originally compared budgeted year costs with the actual costs of two years prior, rolled forward for inflation. The new methodology further compared the two-year-old data with costs of the year prior to that and took the lower of the two; i.e., in effect, a cap was placed on base-year costs. The benefit of using the year prior to the base year is that audits already have been completed and actual inflation rates are available.

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[1]See Appendix C.

Further changes made in 1977 included: an increase in the occupancy standards by five percent for both classes of providers and a separate occupancy standard for pediatric beds; the calculation of a lower rate for administrative days and the deduction of these days from the per diem calculation; and the imposition of the Medicare routine per diem limitation within the Medicaid program.[1]

Proposed changes to the outpatient reimbursement policy were more severe. As mentioned above, outpatient reimbursement was based on a cost-to-charge ratio set in the base year. The new methodology stated that total outpatient costs would be taken from the year prior to the base year and not adjusted for inflation. Total outpatient charges (revenues), however, would still be taken from the base year. The result was an extremely reduced cost-to-charge ratio, since obviously the charges in the base year (denominator) would be higher than charges in the year prior to the base year.

The refinements were proposed to become effective by October 1, 1977 for FY 1978. However, because of a delay in HEW approval, the rates did not go into effect until January 1, 1978. Thus, the rate calculated under the old methodology was in effect during the period from October 1, 1977 through December 31, 1977. On January 1, 1978, when the new rate became effective, over ninety percent of the hospitals experienced an overall rate decrease of almost ten percent. Whereas the old methodology would have allowed an increase of almost fifteen percent from 1976 to 1977 across all hospitals, the new one reduced the increase to six percent. The Massachusetts Hospital Association immediately filed a request for a temporary restraining order to prevent the rate roll-back, which was ultimately denied.

The request for the restraining order is just one of numerous suits that have been filed. The nature and extent of litigation against the program are described in the section on legal challenges to the system. In the following section, the process used by the Medicaid budget analyst is described.

The Medicaid Process

For computing the per diem rate for a hospital, data are taken from the RSC-401. In view of the changes in the methodology made in 1978, mentioned above, the administrative day rate is calculated first, since it is deducted from total inpatient cost.[2] The total base-year nonoperating costs of the provider are divided by its total base-year costs to produce a loading factor. The nonoperating allowable costs include all depreciation (except

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[1]W. Grieco, "Note on Hospital Charge Control in Massachusetts," Harvard School of Public Health, 1978.

[2]An administrative day is defined as an inpatient day requiring a lower, and therefore, less expensive level of care.

that on major movable equipment), interest expenses, rental payments, property taxes, and legal fees. Total costs include depreciation, calculated on historical cost, of major movable equipment. The loading factor is multiplied by total base-year inpatient operating costs to arrive at inpatient nonoperating costs. This is then added to base-year allowable routine operating costs (adjusted for inflation) to produce total rate-year routine cost. Total rate-year routine cost is divided by adjusted base-year routine inpatient days to produce a routine per diem rate.[1] The routine per diem rate is further adjusted by application of the Medicare routine inpatient per diem limit imposed by Section 223 of PL 92-603. The difference between the Medicare rate and the routine per diem is called the routine per diem restriction and (if positive) is subtracted from the routine per diem to produce the administrative day rate. The Medicare routine per diem limit simply becomes the limit for the Medicaid administrative day rate.

The inpatient per diem rate is then calculated. Total inpatient allowed operating costs are determined for the base year. A two-year inflation factor is added to produce rate-year inpatient allowed operating costs. Inflation is computed by compounding two annual inflation factors--one for the base-to-intermediate year and one for the intermediate-to-rate year. The inflation index used is that developed by Harbridge House and also used by 409. Three years of inflation--base year, intermediate year, and rate year--are calculated. A classification scheme which assigns hospital costs to one of fifteen cost categories (proxy indicators) is used. Each category is weighted according to its cost to total hospital costs. An average composite index per year is then computed. As mentioned above, as a result of the methodological changes in 1978, the recognition of base-year operating costs is limited by the costs of the year prior, adjusted for one year of inflation. Next, base-year uninflated major movable equipment depreciation is added to other nonoperating costs. The next step is to determine allowed inpatient days, which is the sum of adjusted medical/surgical, maternity, and pediatric inpatient days. Patient days are adjusted according to the higher of actual days or the following percentage of available days in the base year.

Department	Percent Teaching	Percent Nonteaching
Maternity	65	65
Pediatric	80	75
Medical/surgical	85	80

The inpatient all-inclusive per diem rate is then the quotient of the rate-year total inpatient cost less cost attributable to administrative days over allowed inpatient days, less base-year administrative days.

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[1] An adjusted routine inpatient day is the higher of actual routine inpatient days or eighty percent (eighty-five percent for teaching hospitals) of the total number of routine available bed days in the base year.

Providers that have experienced significant cost increases after the base year may petition for recognition of these costs through the administrative adjustment mechanism. The Commission will consider administrative adjustments for the following reasons:

- error in calculation of per diem rate;
- costs necessary to satisfy requirements of a governmental unit relative to the safety of patients, quality of service, or provider's fiscal operations;
- arm's length transfer of ownership of the provider for good and valuable consideration (the adjustment is limited to reflecting only increases in nonoperating costs resulting from the transfer);
- unusual or unforeseen increases in reasonable operating costs, not compensated for by the inflation factor, that would threaten the financial stability of the hospital;
- DON-approved capital expenditure or change in service;
- a substantial program change not requiring a DON;
- inability of the hospital to use a significant portion of its licensed beds for reasons other than geographical underutilization, refurbishing, or seasonable utilization patterns;
- transfer "on" of costs; e.g., physicians who used to bill directly are now billing through the hospital;
- significant program or reporting changes in the base year in the outpatient area, which make the base-year comparison to the year prior inequitable (volume increases are not sufficient reasons);
- hardship imposed by application of Medicare 223 limitations; and
- DPH authorization to temporarily remove beds from service; the hospital must indicate its intention to maintain the bed removal for twelve consecutive months.

Administrative adjustments provide the only area for negotiation between the Rate Setting Commission and the hospitals. Hospitals must back their cases with well-documented evidence that they are entitled to such an adjustment, since the "burden of proof" lies with them.

Resources and Time Line Used for 409 and Medicaid

The following section examines the staffing, levels of effort, and costs of running both the Medicaid and the 409 program.

The 424/409 Program

The staff that was assigned within the Bureau of Hospitals in the beginning year of the prospective rate-setting program consisted of ten full-time auditors, a half-time bureau director, one full-time lawyer and one full-time support staff.[1] It is also estimated that one of the three commissioners was involved full time and the executive secretary twenty percent time on matters within the Bureau of Hospitals. Costs of these personnel have been allocated to the 424 program to produce a total cost of about $250,000 for the first year of operations.

As can be seen in Table 3, the staff of 409 increased in 1977 as a result of the research grant awarded by the HCFA for developmental work in the areas of refining the inflation index and developing the groupings and case-mix methodologies. The grant, awarded on a federal/state cost-share basis, more than doubled in the second year in the areas of further increased staff and subcontracts. The third year predicts a decrease in these areas from the second, but still represents significant funding of the previously mentioned studies. Blue Cross also contributes to the research efforts by donating the use of its computer facilities up to a cost of $11,000 per month. The number of Bureau staff assigned to operations has remained the same throughout with the exception of another audit staff member added in fiscal 1978 and a full-time assistant Bureau director who was added in FY 1979.

The analysts review the budgets of 120 acute care hospitals and seventeen psychiatric hospitals, which came into the system in January 1979. The regulations promise a sixty-day turnaround time between submittal of a completed application and a decision from the Commission. To satisfy this requirement, the months of May and June are spent reviewing the submissions of hospitals with fiscal years ending June 30. There are about twenty of these, mainly publicly supported institutions. The busiest period, however, is during the months of August and September, when applications from hospitals with fiscal years ending September 30 are processed. During this period, the full-time services of about 15 audit analysts and supervisory personnel

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[1]The first year would be considered as Chapter 424, the interim system.

Table 3
OPERATING AND DEVELOPMENT COSTS OF PR SYSTEMS IN MASSACHUSETTS

6/1 - 6/30 Fiscal Year	PR System	Type of Cost	FTEs	Position	Source Salaries & FB		Activity/ Amount	Computer	Travel	Other Direct Costs	Total Costs
1975	Medicaid	Operating	2	Audit staff[1]	TOTAL	52,900	--	--	--		
			1	Lawyer						1,000	
										TOTAL	53,900
1976	Medicaid	Operating	2	Audit staff[1]	TOTAL	73,019					
			1	Lawyer						1,000	
										TOTAL	74,019
	Charge Control[2]	Operating	10	Audit staff							
			1/2	Bureau Director							
			1	Commissioner	TOTAL	240,586					
			1/5	Exec. Secretary							
			1	Clerical						6,000	
			1	Lawyer						TOTAL	246,585
1977	Medicaid	Operating	2	Audit staff[1]	TOTAL	81,205					
			1	Lawyer						1,100	
										TOTAL	82,305
	Charge Control	Operating	9	Audit staff							
			1	Audit Supervisor							
			1/2	Bureau Director							
			1	Commissioner	TOTAL	269,507					
			1/5	Exec. Secretary							
			1	Clerical						5,000	
			1	Lawyer						TOTAL	274,507
	Charge Control	Development[3]	1/2	Project Director	TOTAL	99,795	Inflation Index/ 14,362		906	13,449	
			1/2	DP Systems Analyst							
			1/4	Programmer							
			1/2	Sup. Prog. Analyst			Groupings/ 11,313				
			1	Economist							
			1/2	Chief Methods & Systems Analyst			Case mix/ 10,711				
			1/2	Sr. Accountant							
			1/2	Semi Sr. Accountant							
			1	Support staff							
										TOTAL	150,536
1978	Medicaid	Operating	2	Audit staff[1]	TOTAL	91,057				1,100	
			1	Lawyer						TOTAL	92,157
	Charge Control	Operating	10	Audit staff							
			1	Audit Supervisor							
			1/2	Bureau Oirector							
			1	Commissioner	TOTAL	350,501					
			1/5	Exec. Secretary							
			1	Clerical						4,000	
			1	Lawyer						TOTAL	354,501
	Charge Control	Development	1	Project Director	TOTAL	214,733	Inflation Index/ 42,113		2,120	27,875	
				DP Systems Analyst							
			1/2	Programmer							
			1	Sup. Prog. Analyst			Groupings/ 41,571				
			2	Economists			Case mix/ 51,150				
			1	Chief Methods & Systems Analyst			Planning/ 19,927				
			1	Sr. Accountant							
			1	Semi-sr. Accountant							
			2	Support staff							
										TOTAL	399,490

Table 3 (continued)

6/1 - 6/30 Fiscal Year	PR System	Type of Cost	FTEs	Position	Salaries & FB		Activity/ Amount	Computer	Travel	Other Direct Costs	Total Costs
1979	Medicaid	Operating	3	Audit staff[1]	TOTAL	115,200				1,100	
			1	Lawyer						TOTAL	116,300
	Charge Control	Operating	10	Audit staff							
			1	Audit Supervisor							
			1/2	Bureau Director							
			1	Commissioner	TOTAL	411,460					
			1	Asst. Bureau Dir.							
			1/5	Exec. Secretary							
			1	Clerical						4,500	
			1	Lawyer						TOTAL	415,960
	Charge Control	Development	1	Project Director	TOTAL	349,015	Inflation Index/ 27,751	132,000[4]	3,050	50,370	
				DP Systems Analyst				15,000			
			1/2	Programmer							
			1	Sup. Prog. Analyst			Groupings/ 30,258				
			2	Economists			Case mix/ 40,340				
			1	Chief Methods & Systems Analyst			Planning/ 38,447				
			1	Sr. Accountant							
			1	Semi-sr. Accountant							
			2	Support staff							
										TOTAL	686,231
1980	Charge Control	Development	1/2	Project Director	TOTAL	234,078	Planning/ 18,520	77,000[2] 15,000	1,850	34,958	
			1/2	DP Systems Analyst							
			1/4	Programmer							
			1/2	Sup. Prog. Analyst							
			1	Economists							
			1/2	Chief Methods & Systems Analyst							
			1/2	Sr. Accountant							
			1/2	Semi-sr. Accountant							
			1	Support staff							
										TOTAL	381,406

Source: Massachusetts Rate Setting Commission

Note: Discrepancies of $1 in the total costs column are due to rounding.

[1] 1976 was the first year of the Charge Control Program (PR for charge-based providers); all of the costs for this program during FY '76 may be viewed as developmental, leading to the permanent legislation which was to become C. 409. All of the costs also reflect startup, since all personnel positions were new and necessitated by the passing of C. 424.

[2] Blue Cross allows use of its computer facilities to the Commission for developmental work on C. 409, up to $11,000/month.

[3] Grant started in November 1977. Costs and FTEs have been adjusted to reflect a six-month period.

[4] One FTE lawyer paid by Blue Cross and one FTE paid by the state. Each works across both programs.

are needed. Psychiatric hospitals have a fiscal year ending December 30 and are reviewed during November and December. (Refer to Figure 9, which depicts the time line for the 409 review process.)

In order to review the large number of budgets during the relatively short time frame, the staff organized into teams of analysts. Four or five teams of budget analysts are headed by a "referencer," usually a senior analyst, who has full-time responsibility for his/her team and is responsible to the 409 program manager. The analysts and referencers are drawn from the Bureau's audit team and are generally B.A. accountants, CPAs, or MBAs. During the 409 budget review cycle, these auditors are assigned full time to the budget review process.

The manager of the 409 program channels the budget submissions to a referencer, who assigns the budget to a team analyst. The analyst reviews the budget, prepares a description of the results of the review, and details the staff recommendation. Internal work papers and formal recommendations are then turned in to the referencer for review. All reviews are also subjected to a final review by the program manager. Final recommendations are then passed on to the commissioners,[1] who rarely disagree or question staff recommendations. Budgets are acted upon during Commission meetings. As many as eighty hospital budgets may be acted on during one Commission meeting, which also addresses other Commission matters.[2] Should a disagreement or question arise over a particular budget, the matter is set aside for further review. Because the Commission prefers to be unanimous in its vote, and because the specificity of Regulations promulgated by the 409 program severely limits both the staff and commissioners from exercising any discretion, negotiations and disagreements are not common at public meetings.

The estimated level of effort to complete the analysis of a hospital submission varies between less than one person day to two person weeks, with one or two hospitals possibly taking longer. The level of effort depends on the size and complexity of the hospital and the completeness of the submission; i.e., whether all backup data have been included. The Bureau also tends to spend more time on hospitals that have challenged its decisions in the past.

Medicaid

When the Medicaid system changed from retrospective to prospective in 1974, no new staff were added. The staff consisted of three full-time

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[1]Massachusetts Rate Setting Commission, Annual Report, 1978.

[2]That is, the business relating to the other four bureaus is also addressed during a session.

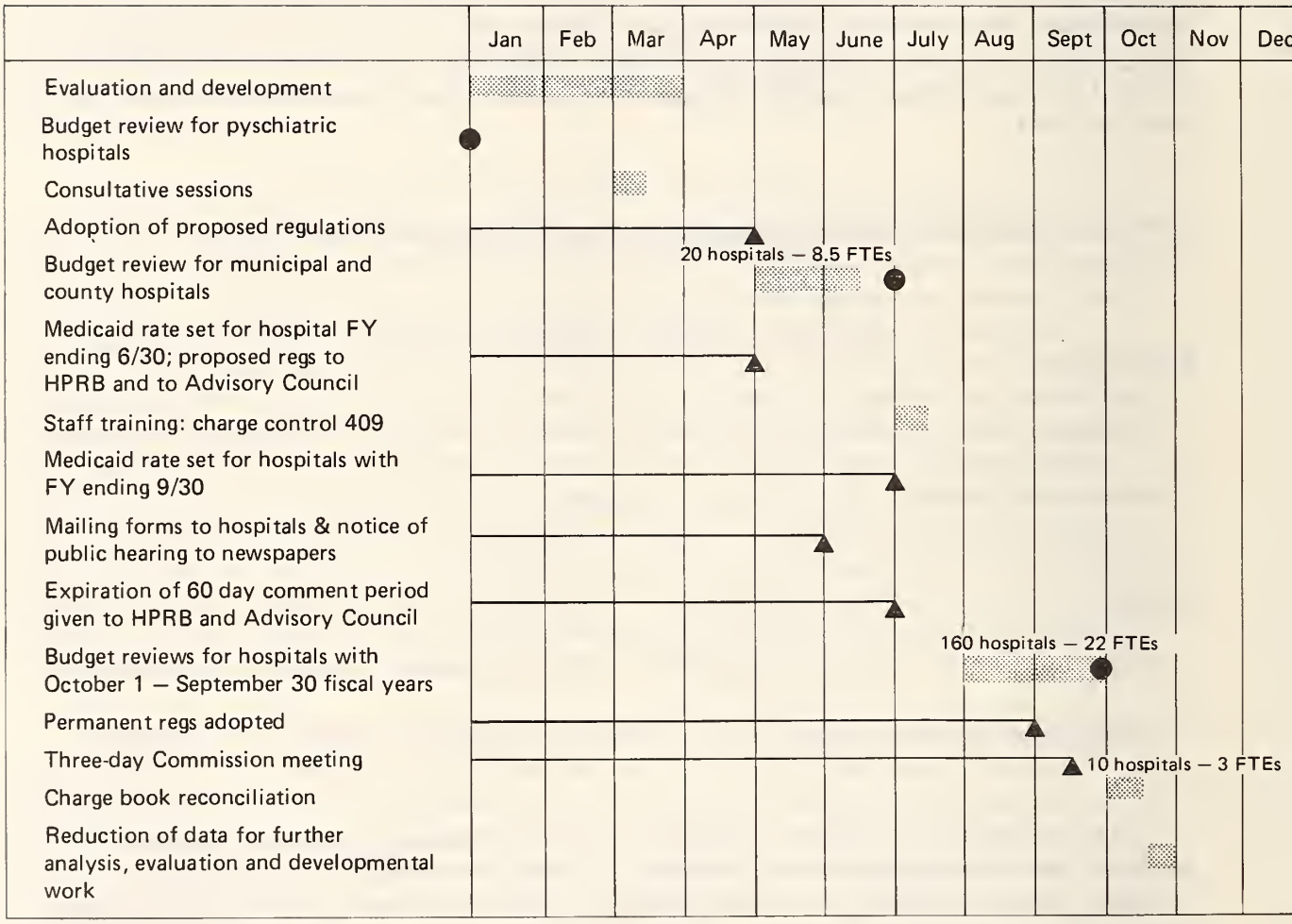
personnel--two auditors, one of whom was managerial, and a lawyer. In fiscal 1979, another auditor was added. As can be seen in Table 4, the costs of running the Medicaid program are extremely low, especially when compared with Chapter 409; the costs for 409 are consistently three to four times as high. However, the data are somewhat misleading: the real costs are deflated significantly by the fact that Medicaid does not bear any cost of hospital audits. The salaries of some thirty full-time auditors are paid by Blue Cross, which performs the audit both for itself and Medicare because it is the carrier for Medicare in the state. Medicaid is thus able to "piggy-back" this audit. Since the audit is the real strength of the Medicaid program--replacing compliance, though equally effective--this represents an important cost savings.

TABLE 4: Operating and Development Costs, Massachusetts PR Systems

	FY '75	FY '76	FY '77	FY '78	FY '79	FY '80
Medicaid						
Operating Costs	54,000	74,000	82,000	92,157	116,300	Unavailable
Development Costs	-	-	-	-	-	-
424/409						
Operating Costs	-	246,585	274,507	354,501	415,960	Unavailable
Development Costs	-	-	149,630	399,490	686,231	381,406

As evident in the time line for Medicaid (Figure 9), the program is not subject to the intensive time constraints that characterize 409. From November through March, state and county hospitals submit cost data in order that Medicaid rates may be set. Rates for these hospitals must be finalized by the middle to the end of March as they affect the state budget, which is set on July 1. By May 1, the Medicaid rate for the 409 program is announced for hospitals with fiscal years ending June 30 and on July 31 for hospitals with fiscal years ending September 30. Proposed regulations are being developed for the upcoming fiscal year during the period May through September. October through the end of January is the heaviest period for administrative adjustments. Also during this time, research is ongoing in the areas of verification of inflation increases, administrative review, and measurement of the effectiveness of controls.

Figure 9
TIME LINE FOR BUDGET REVIEW PROCESS


Jan
Feb
Mar
Apr
May
June
July
Aug
Sept
Oct
Nov
Dec
Evaluation and development
Budget review for pyschiatric hospitals
Consultative sessions
Adoption of proposed regulations
Budget review for municipal and county hospitals
20 hospitals — 8.5 FTEs
Medicaid rate set for hospital FY ending 6/30; proposed regs to HPRB and to Advisory Council
Staff training: charge control 409
Medicaid rate set for hospitals with FY ending 9/30
Mailing forms to hospitals & notice of public hearing to newspapers
Expiration of 60 day comment period given to HPRB and Advisory Council
Budget reviews for hospitals with October 1 — September 30 fiscal years
160 hospitals — 22 FTEs
Permanent regs adopted
Three-day Commission meeting
10 hospitals — 3 FTEs
Charge book reconciliation
Reduction of data for further analysis, evaluation and developmental work

Note: Promulgation of regulations occurs in an 81-day cycle.

● Approval of budgets

▲ Completion

▒ Approximate time frame for activity.

In summary, referring to Table 4, a comparison of the two programs indicates that the 409 system is by far the more expensive to run. However, as stated above, this is misleading with respect to both operations and developmental costs, since the Medicaid program is able to share in the results of the research occurring under 409. A good example is the refinements of the inflation index that have been incorporated into the Medicaid methodology.

LEGAL CHALLENGES TO THE SYSTEM

Overview

Highly cognizant of the risks involved in legal challenges to the system, the Commission has taken a very cautious approach in the development of its regulations for both the Medicaid program and Chapter 409. The Commission has carefully controlled the flow of court cases, and with few exceptions, has been able to use the court decisions to buttress its regulations, although the courts have discouraged use of the court system to resolve disputes between the hospitals and the Commission. In response to the strong legal foundation established by the Commission, the Massachusetts Hospital Association has now resorted to the use of legislative amendments to check the Commission's authority. In the sections that follow, the formal appeal process for both the Medicaid and 409 programs is described, as well as the major legal challenges to both systems.

Appeals Process

The Division of Hearing Officers, located within the state's Executive Office for Administration and Finance, is the formal mechanism through which hospitals may file appeals. Once a hospital files a formal appeal with this division, a hearing officer holds an adjudicatory hearing. The Commission's legal staff of six attorneys also conducts fact finding and takes depositions that are filed with the hearing officer.[1] Once all testimony and evidence are submitted, a written decision is rendered and submitted to the Rate Setting Commission.

The decision, however, is not binding on the hospital or the Rate Setting Commission. Should the Commission consider the "hearing officer's statement of reasons inadequate to determine a fair, reasonable and adequate rate," the Commission may return the decision for further investigation. The Commission votes on a recommended decision at weekly public Commission

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[1]The Attorney General's Office represents the Commission in any litigation.

meetings. Should the hospital choose to appeal the decision of the Commission, a petition for review in the Superior Court, the first court of appeals, must be filed within thirty days.[1]

Historically, the Division of Hearing Officers has been understaffed and not able to handle the voluminous number of appeals. Of the 200 appeals filed under the Medicaid system since 1974, only sixteen were resolved during the summer of 1978.[2] The authority of the hearing officer has been the subject of dispute for a number of years. It has been the position of the Commission that the role of the hearing officer is to determine whether or not the regulations, as written, have been applied fairly to the specific provider. Providers, however, often try to get the hearing officer to render judgments on the "goodness" of the regulations. According to the Commission's legal staff, the Commission should not accept the decision of the hearing officer when this has been done.

In order to resolve the seeming uncertainty surrounding the scope of authority of the hearing officer, the Commission requested a ruling on the issue from the attorney general. The attorney general's ruling identified three areas of inquiry open to the Division of Hearing Officers:

- The hearing officer may inquire whether the Commission, through its staff, has properly applied the general rates/formula to the particular facts at hand.

- The hearing officer may determine whether the Commission has correctly interpreted and applied an ambiguous regulation not previously construed by the Commission.

- Finally, the hearing officer may also determine whether, on the facts of a particular case, a rate is so low as to violate the "adequate, fair and reasonable" standard of Section 36.[3]

The Commission considered this decision a favorable one but still reports that the Division of Hearing Officers continues to issue decisions on

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[1]Massachusetts Rate Setting Commission, Annual Report 1977.

[2]This situation has recently been rectified and the Division is presently fully staffed.

[3]Massachusetts Rate Setting Commission, Annual Report 1978.

issues that are not within their jurisdiction.[1] According to the Commission, the inconsistent action of the Division "has been detrimental to the parties in preparation of cases, since the scope of review remains an issue." This situation is particularly applicable to the Medicaid program in that hospitals do appeal per diem rates. To date, the issue in the charge control program is with the actual regulation rather than whether hospitals have been treated fairly under the regulation.

Legal Challenges to Chapter 409

There have been several legal challenges to Chapter 409 that have shaped the direction of the program and the rigor of the methodology employed to date. Although the Commission contends that the outcomes of both cases have demonstrated the "inherent soundness and resiliency of the budget approval system," the findings of this case study do not totally support this assessment. Indeed, the impact of the first major decision constitutes a major weakness remaining in the 409 system. The first actual challenge to the system was a procedural issue and occurred in the first months subsequent to the effective date of Chapter 409. The MHA sought a temporary injunction to enjoin the Commission from issuing permanent regulations on the grounds of defective rule making. The Commission, because of the short implementation time, had issued its regulations prior to establishing the Hospital Policy Review Board. The MHA challenged the Commission's authority to issue regulations or hold public hearings, given that one of the rights of the HPRB was to make presentations at public hearings on regulations. The result of this case was that, through judicial order, the regulations were continued on an emergency basis until such time as the Board was appointed.

Background

The previous discussion has alluded to the Commission's intention to conduct compliance review as part of the 409 process. The authority of the Commission to conduct compliance is considered the first significant challenge to Chapter 409. The issue arose at the end of 1975 (FY 1976), when the Commission issued regulations outlining the method by which compliance review would be conducted. According to Commission regulations, actual cost and charge data had to be submitted to the Commission by the hospital four months after the end of the fiscal year. The Commission then compared the hospital's ratio of actual costs to actual charges. The method used by the Commission involved a reconstruction of allowable revenue by use of actual inflation and volume data and a comparison of the reconstructed revenue

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[1]The Division of Hearing officers has intervened and filed an appeal to test the validity of the opinion.

with actual revenue for the next year. If the hospital had fallen below the approval rate for FY 1976, the Commission notified them that they must reduce their current charges to recover revenue generated in excess of the approved ratio.[1]

Preliminary compliance studies conducted by the Commission approximated gross excess revenue generated by hospitals for FY 1976 to be $38.3 million dollars.[2] These violations were attributed partly to the revisions of the inflation indices, which were adjusted to reflect actual 1976 data; the balance of the violation was attributed to actual 1976 costs in excess of the computed 1976 maximum allowed costs, or to actual 1976 revenues in excess of those allowed.[3]

The Affiliated Hospital Center, a corporation of three Boston-based teaching hospitals, filed suit to enjoin the Commission from performing compliance review. As a result of this suit, the Commission was permanently enjoined from enforcing its compliance regulation, which provided for "recapture" of a hospital's excess revenue from charges provisionally approved by the Commission before the actual cost data were available. The judges ruled that "the entire structure of Chapter 409, is that of an unconditionally prospective system of charge modification application and permanent approval. . . . Commission action is limited to approval or disapproval in whole or in part. Absolutely no provision is made for tentative or conditional approval [of rates]."[4]

The decision of the court has had severe ramifications for the entire system. From the Commission's perspective, the decision forced the premature implementation of a prospective system before the staff had the necessary techniques to administer it. The thrust of the Commission's argument is that "the intent of Chapter 409 was to move to prospectivity only after a substantive development and refinement of budget review methodologies."[5]

The Commission pursued three options in response to the court order. The Attorney General's Office sought relief from the order through the appeal process. Anticipating that a definitive decision would not be made prior to

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[1]Massachusetts Rate Setting Commission Memorandum, 1977.

[2]One hundred and twenty hospitals were studied, of which ninety-one were found out of compliance; $38.3 million represents approximately 2.6 percent of 1976 projected actual revenue for these ninety-one hospitals.

[3]Massachusetts Rate Setting Commission Memorandum, Preliminary Compliance Study, February 1977.

[4]Affiliated Hospital Center, Inc. v. Werner, Suffolk County, C.A. No. 19457 (1977) (Affiliated I).

[5]Massachusetts Rate Setting Commission Memorandum, June 1977.

the next budget review cycle, the Commission issued a new regulation changing the base year from two years to three years prior to the rate year. Third, the Commission prepared legislation that sought to clarify its authority to engage in compliance review. However, it was not considered politically prudent to file legislation at this time as hospitals were not considered to be "in the mood for statesmanship."[1]

MHA Role

The Massachusetts Hospital Association stayed on the sidelines of this suit, neither supporting nor condemning the action taken. MHA was indeed in a peculiar position for two reasons. First, it had worked with the Commission in designing the compliance provisions, and second, not all member hospitals would benefit from the proposed rule change.

Although the decision had prohibited the Commission from reviewing hospital budgets after the fact, the judge recognized in his opinion that "the Commission was correct in wishing to incorporate actual inflation, volume, etc., into the Chapter 409 system, and that this could be done by requiring hospitals, in their budget submissions, to adjust cost figures by taking those into consideration." On this basis, the Commission changed, through emergency regulation, the base year for the review of hospital budgets from two years to three years. This decision to change the base year was made in June and regulations were issued in July.[2] MHA strongly protested that this change did not allow sufficient time for their inquiry. This decision, coupled with a tightening of the Medicaid methodology instituted that year, severely eroded the relationship between the Commission and the hospitals. As was expected, this change was challenged by the Affiliated Hospital Center. The MHA again remained silent on the issue because the impact on their membership was varied, hurting some while benefiting others.

Affiliated Hospital Center, Inc. v. Weiner et al.

The Affiliated Hospital Center challenged the Commission's new regulation, inter alia, on grounds of being in violation of the Affiliated I decision. Affiliated contended that the three-year base, in essence, reinstituted a compliance system. The Commission won this round of litigation, as the court upheld the legality of the revised base year. The

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[1]Rate Setting Commission Memorandum to Governor Dukakis, July 1977.

[2]The timing of the decision put the Commission in a severe bind. Regulations had to be promulgated by July, which left the Commission only three weeks to redesign the system.

court found that cost and revenue data from prior years were only being used "for the purpose of establishing allowable rates for the upcoming year and not to recoup prior years' excess charges or costs."[1]

It should be understood that the court's decision was based upon consideration of administrative law ground rather than on the reasonableness of one methodology versus another.[2] The basic issue in the case was that of the deference of an agency, in a situation where the agency is interpreting its own statutory authorization, in the context of a new statute in which the agency has developed. The question the court decided upon is a fundamental principle in administrative law: what deference is owed to the agency in the interpretation of the statute where the statute is clearly ambiguous? The agency must be able to explain in a reasonable manner why it chose to so interpret its statute rather than in some other way. The agency is not required to justify the "reasonableness" of the methodology it sought to implement as hospitals desire it to do. For the court to have decided against the Commission, the Affiliated Hospital Center would have had to prove that the agency acted in an arbitrary or capricious manner.

The Massachusetts Rate Setting Commission feels that it gained tremendous legal ground with this decision. In fact, it views the decision as giving the Commission broad authority for the development of substantive standards, which are delegated to the Commission in Chapter 409. The court also noted in its decision that Chapter 409 provides several formal mechanisms for resolution of disputes in the regulatory process. The court suggested that the Hospital Policy Review Board is the proper vehicle for review of proposed regulation and contended that it should be used. The court in essence frowned upon using litigation as the channel of recourse and noted that, given this instance, where a formal mechanism was available for appeal, sufficient weight must be given to the regulations duly adopted by the Commission.[3] However, the appeals process, according to the ruling

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[1]Rate Setting Commission, Annual Report 1978. This decision was appealed by Affiliated Hospitals. The Appeals Court upheld the decision of the Superior Court. Affiliated Hospitals Center, Inc. v. Rate Setting Commission, Appeals Court S. 78-581, May 16, 1979.

[2]The Affiliated Hospital Center would offer an opposing viewpoint on the merits by which the case was decided. The AHC contends that the court did not understand the implications of the methodological change being instituted, whereas the court had a much better understanding in the first decision.

[3]Massachusetts Rate Setting Commission, Annual Report 1978.

of the attorney general, does not have sufficient scope to include a ruling on the merit of regulations promulgated by the Commission.

The most recent challenge to the 409 system was initiated as a result of the significant methodological changes introduced in FY 1979. As previously discussed, a major change in the methodology used for determining increases in working capital requirements resulted in a much more conservative increase for hospitals than originally proposed. Although a considerable increase in charges above the year prior was allowed, the Affiliated Hospital Center once again took action and filed for a temporary injunction against the proposed change. The MHA also joined in on this attempt to enjoin the Commission from implementing this change. Twenty-five hospitals through the MHA filed an Amicus brief; that is, a statement in support of the Affiliated claim.[1]

Legal challenges have not been limited to those initiated by the hospital industry. The attorney general's office, on behalf of the Commission, initiated two suits this past year in what is described as "part of the attorney general's undertaking of affirmative litigation." The only mechanism the Commission has for penalizing a hospital for "overcharging" or false reporting is through court action. This has been done infrequently for two reasons. First, in the case of the charge control program, the Commission has no formal mechanism for determining if a hospital has overcharged; i.e., no audit. When this is discovered, it is usually accidentally. Second, the staff are somewhat hesitant to seek court action because it does constitute a civil crime. In short, the limitation of remedies appears to be excessive in light of the goals the Commission is seeking to achieve.

Of the two cases instituted, one was for overcharging for CAT scanner services and the other was for false reporting on the 409 charge control forms. To date, these cases have not been decided. The hospitals are, however, subject to a fine that may be set anywhere from one cent to one thousand dollars per day. One of these cases will most likely be settled out of court. In the case of false reporting, the hospital has moved to test the sufficiency of the statute. The issue to be tested is that of "intent."[2]

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[1]Subsequent to this action, the Commission amended the working capital requirement to include an allowance for Medicaid, retroactive to the start of the fiscal year.

[2]It is interesting to note that the Affiliated Hospital Centers will again be challenging the authority of the 409 statute.

Legal Challenges to Medicaid Program

Overview

There have generally been three types of challenges to the Medicaid program since it adopted a prospective methodology; the noteworthy challenges have been lodged for the most part by the Massachusetts General Hospital. The reasonableness of Medicaid rates, the use of information bulletins versus regulations, and the validity of the latest amendment to the state Medicaid plan for FY 1978 have all been the subjects of recent legal challenges. For the most part, the Medicaid program has withstood these challenges very well and has been able to preserve the integrity of the system. The courts have deferred to the jurisdiction of the agency to reasonably interpret its regulations. The following section examines a number of the policy issues raised in these cases and discusses their impact on the development and operation of the Medicaid prospective reimbursement system.

Litigation

The most significant case heard to date has been Massachusetts General Hospital v. Weiner et al. 569 F.2d 1156 (January 25, 1978). In this case, first filed in 1975, Massachusetts General Hospital sought declaratory and injunctive relief from the Commission's prospective inpatient hospital reimbursement methodology. The key issues in this case were whether the Massachusetts plan of prospective reimbursement (instituted in 1974) met the "reasonable cost" requirement of the federal Medicaid regulations, whether the prospective reimbursement plan conformed to various procedural requirements of Massachusetts state law, and finally, whether the reimbursement plan protected the hospital's constitutional rights and its rights of equal protection and due process allowing for a public hearing on the rates. Although public hearings were held before the Commission implemented the prospective reimbursement system, the Commission does not hold individual hearings before rates are set. There is a critical distinction recognized in Massachusetts case law, which was used to decide the merits of this claim, that "regulations of general application must be preceded by hearing whereas in specific applications of those general regulations, no prior hearings are required."[1]

Constitutional Claims

Concerning the issue of due process, the court decided that the Massachusetts prospective rate system provided adequate opportunity to be heard and to contest the rates set for its services. MGH claimed that, by virtue of

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[1]J. Garrity, Order granting defendant's motion for summary judgment, Civil Action No. 75-2651-G. February 4, 1977.

the fact that the Commission established differential rates for other health care facilities, the MGH was denied its equal protection of the law. Using the traditional equal protection test, thereby questioning whether the legislation had some "reasonable basis," or whether it was "rationally related to a legitimate government interest," the court found that the regulations promulgated by the Commission were indeed clearly rational.[1] The final issue raised by the MGH was that of contract impairment. MGH claimed that the Commission "interfered with its contract rights by preventing reimbursement of reasonable cost for services rendered, thus violating the impairment clause of the U.S. Constitution." On this issue the court found that, on the basis of entering into its annual agreement with the state, MGH must accept those reimbursement rates subsequently established by the Commission.[2]

The Massachusetts Hospital Association has followed up on this case by filing suit, naming the USDHEW (Califano) as a party. This case, Massachusetts Hospital Association v. Califano et al., U.S.D.C., Mass., is currently in the pleading stage. A number of the issues to be decided in this case are similar to those in the above-described case. A key issue to be resolved, however, is HEW's approval criteria for the change in rate-setting methodology adopted by the Commission in December of 1977 and effective 1978. As discussed earlier, this methodology change embodied several significant changes in the inflation factor, occupancy penalties, and administrative review process.

There are several other cases filed by individual hospitals that have been decided and are worth noting.

In MGH v. RSC (1975), the Massachusetts General Hospital challenged the legality of the Rate Setting Commission's use of administrative bulletins as a mechanism to interpret a regulation. The information bulletin in question was one that issued an explanation of several provisions of the regulations dealing with applications by providers for adjustment of rates due to program changes. The court upheld the legality of the use of administrative bulletins to further clarify regulations without going through the procedures required for promulgation of a regulation.

There have been few cases that have been lost by the Rate Setting Commission. In 1977, however, Massachusetts General Hospital did successfully challenge the Commission's use of a cap in setting rates. The issue in this case involved the legitimacy of capping Medicaid rates by limiting the base-year rate to seven percent of the prior-year ratio. The court decided against the RSC, upholding the use of a cap as inconsistent with the reasonable cost requirements under Medicare.

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[1] J. Garrity, Order granting defendant's motion for summary judgment. Civil Action No. 75-2651-G. February 4, 1977.

[2] Ibid.

In Mt. Auburn Hospital v. Massachusetts Rate Setting Commission, a number of key concerns of Massachusetts hospitals were considered. Mt. Auburn Hospital, in an appeal filed with the Division of Hearing Officers, claimed that the Medicaid methodology did not "determine a fair, adequate and reasonable rate for its facility." The salient points of the hospital's argument were that the methodology failed to consider expenses such as salaries and utilities, which rose more than the allowed twenty-one percent inflation factor, and that the methodology failed to recognize increased intensity of patient care.

The hospital argued, in its appeal to the tentative decision handed down by the Division of Hearing Officers, that the hospital's calculation of its inflation factor was more accurate than the calculation of the Massachusetts Rate Setting Commission. The hearing officer found that the burden of the hospital was not to demonstrate that its own predictions were more accurate, but rather to prove that the rate set by the Commission was not fair, reasonable, and adequate, or was so unreasonable as to be considered arbitrary and capricious. A decision on this case is still pending.

The issue of compliance has posed problems for both the 409 charge control program and the Medicaid program. As discussed previously, the Medicaid regulations allow the Commission to "at any time and upon its own motion, review an approved rate upon notice to the hospital."[1] The scope of this rate review was challenged in Pentucket Manor Chronic Hospital et al. v. Rate Setting Commission et al. In an appeal to the Division of Hearing Officers, the hospital claimed that the Commission had adjusted its rate retroactively after the effective date of the rate. The thrust of the hospital's argument was twofold. First, they contended that the Commission's authority to adjust costs was limited to situations where the provider's costs on its books and records did not match those costs reported to the Commission. Second, the hospital argued that, "in order to be consistent with the notion that rates are permanent prospective rates," retroactive adjustments must be limited.

The Division of Hearing Officers upheld the authority of the Commission to review an approved rate under the circumstances presented in the case. This decision, although only at the Division of Hearing Officer level, adds significant strength to the Medicaid program.[2] Unlike the 409 charge control program, the Medicaid program can currently determine the reasonableness of the base-year costs being used to set prospective rates. Hospitals, on the other hand, argue that the primary benefit of a prospective reimbursement system is the establishment of a final rate on or before the effective date of the rate. As Pentucket Manor argued, this then permits them to "better plan for their cost-savings for the upcoming year."

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[1]Medicaid Regulation 114.1 CMR Rate Setting Commission.

[2]The hospital has recently appealed this decision.

RATE-SETTING INTERACTIONS

In this section, those agencies and organizations that are currently involved in some aspect of the rate-setting process in Massachusetts are identified. The nature of the interaction (coordination) among these groups and, where possible, an assessment of the impact each of these groups has had on the evolution and current direction of the system are also offered. For the most part the interactions described are those of the 409 program; when analyzing interactions, it was extremely difficult to separate the two systems. Medicaid's formal mechanism for input is the Commission's Advisory Council. Research indicates that this council meets infrequently and has extremely limited input into the setting of Medicaid rates.

Formal Linkages

There are four groups that have been most intimately involved in both the evolution of the charge control legislation and the ongoing development of the program. They are the Massachusetts Hospital Association, Blue Cross, the Department of Public Health, and the Department of Public Welfare; the Medicaid program is administered under the last group. Commercial insurance companies, health system agencies, unions, PSROs, the medical society, and the legislature have been involved to a lesser extent. The influence these latter organizations have brought to bear on the system has been minimal--for the most part, in direct proportion to their participation in the system.

This situation is most likely the result of several factors. First, the Commission's regulations and reimbursement methodologies are extremely technical; most individuals lack the sophistication to understand the dynamics of the system. Second, for these organizations, the need to understand the system is not an urgent one; the system has either no direct impact on the organization or a positive impact. Third, the authority to influence the system (e.g., through legislative mandate) does not exist, as in the case of the planning agencies.

The Massachusetts Hospital Association

The Massachusetts Hospital Association is widely known throughout the hospital industry as a strong and influential organization. MHA's more than 180 member hospitals represent some of the most prestigious and powerful medical and research institutions in the country. The power and diversity of this Association's membership has necessitated that the MHA take a selective and cautious approach in its relationship with the Commission. The Association is definitely in a difficult position vis-a-vis the broadly divergent interests of its membership. In general, the Boston-based teaching hospitals are wealthy and sophisticated enough to initiate legal suits, which may be in their own best interests but not necessarily in the best interests of small community hospitals.

MHA Services. MHA's primary function is that of representing and serving the interests of its diverse membership. In order to accomplish this, the MHA employs a staff of approximately 150. Of these, about forty percent provide general membership services and sixty percent are employed in service programs such as management engineering. Over the years, the MHA has also built up its financial staff such that it now has five full-time professionals dealing with fiscal and regulatory matters. MHA's major membership services are similar to those of other large hospital associations: the Association works for the enactment of health-related legislation, serves as a coordinator for hospitals in reimbursement matters, collects and analyzes data, assists hospitals in planning activities associated with PL 93-641, conducts a wide range of shared and fee-for-service programs, and provides technical assistance to many hospitals.

MHA Cost Containment Activities. As part of the national AHA voluntary cost containment efforts, the MHA has established a Voluntary Cost Containment Committee. The stated objective of this committee is "to encourage the containment of health care costs in Massachusetts at the lowest possible level consistent with sound medical practice and the needs of the patients." Those represented on the committee are MHA member hospitals, the Massachusetts Medical Society, Federation of American Hospitals, Blue Cross/Blue Shield, Health Insurance Association of America, Associated Industries of America, and the AFL-CIO. The Board of Directors of the Hospital Financial Management Association is also part of this effort. The Committee, in line with the national movement known as the Voluntary Control Effort, has set as its goal a two percent decrease in hospital expenditures over the next four years. The MHA points out, however, that Massachusetts, currently operating below the national average, will not have to reduce expenditures to that level. In line with this effort, the MHA is planning to establish three committees: one that will address cost containment activities of hospitals, another to analyze the incentives in the system to encourage cost containment, and a committee to provide technical assistance to hospitals in establishing cost containment projects.

Interactions. The Massachusetts Hospital Association is directly involved in Commission activities in that Chapter 409 mandates that two hospital representatives on the Hospital Policy Review Board (HPRB) be appointed from a list submitted by MHA. This formal mechanism for input into the Commission activities was something MHA vigorously lobbied for during the legislative development of the bill. There are eleven members on the HPRB, of which only two are hospital members. One member represents the Boston teaching hospitals, the other, community hospitals whose interests may differ depending on the issue. The MHA has had limited impact on the development of Commission policy through the Hospital Policy Review Board. The Board is heavily weighted with a bias toward state regulation and the

interests of the state and thus tends to agree with most Commission recommendations.[1]

There are several other formal mechanisms through which MHA and the Commission interact. Both Chapters 424 and 409 mandated that the Commission consult with the MHA on each of the major changes to be phased in over the years. The approach taken by the Commission has been that of consultative sessions and ad hoc task forces. In earlier years, this approach fostered a much better relationship between the Commission and MHA because there was more room for negotiation. With the introduction of Chapter 409, specific changes in the system were required within defined time lines. The consultation process is still used, but there has not been the same atmosphere of flexibility evident in earlier years. In many respects, the Commission's mandate is a strict one that does not allow for extensive negotiation with the industry. Thus, the consultation process appears to have deteriorated into one of abiding by the letter of the law.

There has been, however, an extensive amount of research conducted over the past two years under the Commission's federal contract. An informal advisory committee was established to work with various groups conducting the research. The MHA contends they have been virtually excluded from the research process. They are most concerned, of course, about the methodology being developed for hospital groupings and cost comparisons to be implemented in FY 1980. Specifically, the MHA is concerned about the data for the groupings taken from the 401 form; they contend that the 401 information does not provide valid information for that purpose.

During 1978, however, there were two areas in which the MHA and Commission worked quite closely. There were numerous consultative sessions, both formal and informal, over the development of the uniform reporting system and the definition of working capital requirements. Unfortunately, the circumstances surrounding the adoption of the working capital requirement served to further erode the credibility that Bureau staff had been building up over the years.

The MHA was extensively involved during 1978 in the Commission's development of a definition of reasonable financial requirements. The Commission wrote an issues paper, conducted public hearings and established several committees to work on the various aspects of financial requirements. For the most part, hospitals were satisfied with the regulations promulgated for FY 1979, which included a generous definition of working capital requirements. The Commission did not continue its threat to require a hospital to use unrestricted gifts, income, and gains from

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[1]In the most recent instance where the Board disagreed, the effect was to make the Commission's decision more stringent.

investment of unrestricted funds as revenue available to offset operating costs.

As discussed earlier, the Hospital Policy Review Board vehemently protested the adoption of regulations that allowed for an average increase in charges of fourteen percent and that did not include "unrestricted" funds. The Commission, which is not bound by the decision of the HPRB, used the emergency regulation once again to tighten the working capital requirement and leave the door open for use of other sources of revenue funds at some point in the future. The Commission's untimely reversal was considered an arbitrary last-minute change.

The MHA has subsequently filed legislation to amend Chapter 409 such that the Commission could not mandate use of a hospital's unrestricted funds. The erosion of the MHA and Commission relationship is not particularly unexpected. As the Commission has begun to implement the more rigorous components of their methodology, the hospitals have far more to lose. One can expect to see the MHA and some of the larger teaching hospitals begin to pay closer attention to the activities of the Commission as they move closer to adoption of a grouping and cost comparison methodology.

The MHA has several other concerns with the rate-setting process in Massachusetts. It maintains that the cost recognition policies of 409 and Medicaid run counter to the planning process in that they do not allow costs of consolidations and mergers; the lack of incentives in the system is also cited as another barrier to cost containment. MHA is pessimistic about the likelihood of full payor participation by 1981, because of the Medicaid situation. MHA contends that the present 409 system will be an ineffective one until Medicaid accepts full cost responsibility; the inability of Medicaid to do this is causing the charge-cost spread to increase geometrically. On the positive side, the Association felt that the 409 had definitely caused an upgrading of Commission staff, but counteracted this optimism by expressing doubts that the state would be able to keep the more talented people. The Association further qualified this statement by saying that the Commission staff tended to be academic and not knowledgeable about day-to-day hospital operations.

In summary, the relationship between the Commission and the MHA since 1975 seems to have steadily deteriorated. The MHA sees the rate-setting methodology, while it may be curbing inflation in the short run, as having possible long-term negative effects. It cites the fact that, over the past five years, there has been an erosion of hospital equity--an increase in both dollars and numbers of operating losses to the extent that fifty-seven percent of hospitals in Massachusetts had operating losses in FY 1977.[1]

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[1]Massachusetts Hospital Association, "Impact: Diagnosing the Financial Illness of Massachusetts Hospitals," June 1977.

If the prospective system is merely depressing the industry and forcing it to reduce its equity, then the objective of changing the industry's spending behavior has not been accomplished, at least in the short run.

Resources Devoted to Rate-Setting Activities. When queried about the amount of resources devoted to rate setting, the Association could not really attach a cost. The Association has a staff of five financial people, of which two full-time equivalents (FTEs) are devoted to working with Chapter 409. In addition to this, a significant portion of the vice president of finance's time is spent at the Commission, as well as legal counsel and time spent by the president. This does not include staff time devoted to the Medicaid system.

Blue Cross

Blue Cross of Massachusetts is the largest single purchaser of health care services in Massachusetts. As of 1976, fifty-eight percent of the state's population were Blue Cross/Blue Shield members.[1] Blue Cross's share of the hospital expenditures in the state amounts to approximately thirty-five percent. Blue Cross enjoys a reputation of being a front runner in the cost containment field and considers itself to be somewhat of an "innovator on the margin"; it has, however, been cautious in its commitment to the 409 charge control program. Blue Cross's current contract extends through 1980. To be sure, a key negotiating point at that time will be the extent of Blue Cross participation in the 409 program; the key variable, however, will be Medicaid participation. Current speculation is that Blue Cross will not agree to come into the system without a similar commitment from the Medicaid program. Even then, the exact nature of participation will be a source of much negotiation.

Blue Cross and the Rate Setting Commission have an unusual relationship in Massachusetts. The initial methodology for 424 was patterned after the Blue Cross contract in effect at that time. The inflation index used in 424 was one developed in 1974 by Harbridge House for Blue Cross and the Massachusetts Hospital Association. Blue Cross also played a significant role as arbiter between the hospitals and the Rate Setting Commission in the initial negotiations to institute the charge control system.

A quick review of Blue Cross's financial situation offers some insight into their active involvement in the charge control legislation. In 1974 and 1975, prior to the implementation of Chapter 424, Blue Cross was in serious financial straits. In 1974 and 1975, it reported losses in net income in the amounts of $27,000 and $20,000, respectively. Blue Cross premiums were increased by forty percent in 1975. In 1976, net income increased by $40,000, which represents the end of the slump that Blue Cross

[1]Massachusetts State Health Plan, 1978.

had been experiencing since 1972. The main reason for the improvement seemed to be the increased premiums; premiums earned an increase of $100,000 (twenty percent) between 1975 and 1976, with Blue Cross maintaining about the same market share.[1]

The ongoing relationship between the Commission and Blue Cross is even more intimate; Blue Cross pays the salaries of about ninety percent of the staff of the Commission, although these people are employees of the Commission and subject to the Commission's hiring and firing practices. These salaries are primarily those of auditors who perform the hospital Blue Cross and Medicaid audits. For its part, the Commission supplies Blue Cross with the 401 and 409 reports needed to administer its reimbursement systems. Blue Cross also underwrites the research effort of the 409 program by allowing use of its computer up to the amount of $11,000 per month. The Commission ratifies the Blue Cross contract and approves rates and final settlements under this contract.

Blue Cross has played many roles throughout the development of the charge control program. During the evolutionary stages, Blue Cross's role has been described as that of a catalyst and key negotiator. The subsequent development of the program has remained a high priority on Blue Cross's agenda. The president of Blue Cross has been an active and vocal member of the Hospital Policy Review Board, which has served as a mechanism not only to protect the interests of Blue Cross but also to "defend the interests of the private insurors." A case in point is the controversial FY 1979 regulations. Blue Cross led the protest over the magnitude of increases that would be allowed by these regulations. Both at public hearings and through the Hospital Policy Review Board, Blue Cross came out vehemently against the proposed regulations.

> We find ourselves testifying today against the methodology which, in fact, from Blue Cross's point of view, would be very beneficial. The system. . . governs the charge-paying public and the commercial carriers, and if their rates go up much faster than ours, then the differential and Blue Cross competitiveness improves. What we find ourselves doing is saying we are here to protect or at least represent what we feel the public should be saying at this particular hearing, even though in the short run it does not benefit Blue Cross.[2]

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[1]Blue Cross Annual Report, 1977.

[2]Statement by Blue Cross at public hearing before the Rate Setting Commission of Massachusetts, August 9, 1978.

The concern of Blue Cross over cost containment is obvious and historically proven, but there are divergent opinions as to how much of this interest expresses or is able to express itself in the Blue Cross contract itself. The inability of Blue Cross to force hospitals to accept cost containment issues through its contract is illustrated by the statement of the Commission in defending the Commission's ratification of the current Blue Cross contract.

> Approval does imply, however, a reluctant recognition that Blue Cross is fundamentally correct: its contractual arrangements with hospitals can encourage hospital operating efficiencies through such devices as the cost limitation and possibly the utilization review provisions; but the arrangements can have at best a marginal but more likely no impact at all in achieving the basic structural reform of the medical care delivery system, and its economic incentives, that [sic] should be the ultimate goal of public policy. Other devices must be used to achieve such objectives. And the Commission cannot, therefore, responsibly seek to force Blue Cross to use its contractual relationship with the hospitals to address such basic structural issues by refusing to approve HA-27 because it fails to address chronic underutilization, physician reimbursement, the implementation of planning goals, and other such matters.[1]

History would seem to substantiate this. In the contract prior to the current one, Blue Cross first introduced an incremental cost limitation, which served as part of the basis of 424. As a result, five hospitals refused to participate. In HA-27 the cost limitation was made an integral part of the contract, and three hospitals refused to participate. Blue Cross must, therefore, pay charges to these hospitals. An attempt was also made to address the problem of hospitals experiencing underutilization. MHA, representing the hospitals, protested. Blue Cross has also consistently refused to involve planners in the contractual process, maintaining that coordination with planning agencies is best achieved outside of the agreement itself.

Blue Cross advances in the area of cost containment have been significant despite the limitations mentioned above. Within the contract there is the cost limitation provision, although in HA-27, this provision excluded outpatient costs. Also, within the contract, there is utilization review, which penalizes hospitals for unnecessarily long patient stays. Applying utilization review to ancillary services was another innovative provision of HA-27. Outside of the contract, Blue Cross has tried to enforce some

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[1]Statement of the Massachusetts Rate Setting Commission concerning Blue Cross Participating Hospital Agreement HA-27, November 10, 1977, p. 5.

planning objectives; Blue Cross has entered into an agreement with HSAs to withdraw its contracts from hospitals that have been recommended for closure by the HSA. In one instance, this has had the effect of helping to close the hospital.

Department of Public Health

The Department of Public Health, under the leadership of its former commissioner, has been an active and vocal participant in both the development and operation of Chapter 409. Located within the DPH are the Office of State Health Planning and the Determination of Need Program. Although there is much potential for interaction between the DPH and Commission, integration of these two agencies has been limited to coordination of activities and data exchange. These are, however, significant first steps toward full integration in the future.

There is no legislatively mandated link between the Department of Public Health and the 409 program. The Secretary of Human Services, however, may appoint two members to the Hospital Policy Review Board; the Commissioner of Public Health has held one of these appointments. The past commissioner chose to be the representative rather than to delegate this responsibility. The commissioner, both from a personal interest and because of the responsibilities of his agency, played an extremely active role in the Commission's activities. In fact, the commissioner's interest was so active as to raise some confusion between the roles of the Rate Setting Commission and the Department of Public Health. Although there is no legislative link between the Commission and the Department of Public Health, there have been numerous interactions, either informally or through interagency agreements.

Interaction with the Determination of Need Program. The interaction between the Determination of Need (DON) Office and the Commission is informal in nature. The Commission has agreed to abide by DON decisions in so far as the costs of an approved DON project are treated as a pass-through. On an ad hoc basis, the Commission does financial analyses of the impact of proposed DON projects on third-party payments and will review proposed financing mechanisms for certain projects that require more sophisticated analysis. Since most of the Commission's activities with the DON program are coordinated through the Office of State Health Planning (OSHP), any joint projects will be discussed in the following section.

Interaction with the Office of State Health Planning. As part of its federal contract activities, the Commission has subcontracted with the Office of State Health Planning to develop formal health-planning and rate-setting linkages. The federal contract covers one full-time staff member from each agency to serve as a liaison. In addition to this, the

OSHP has two full-time staff who have concentrated on rate-setting activities. The major projects undertaken as part of the federal project have been the development of five-year plans for hospitals, the development of standards and criteria, the revamping of the Determination of Need application, and the development of the Health Systems Development Fund. A brief description of each of these projects is included below.

All acute, chronic, and psychiatric hospitals must submit a five-year plan in accordance with the state's Determination of Need regulations. The Rate Setting Commission participated in the interagency committee that designed a uniform format that would include information needed by all agencies. The one section of particular interest, the Cost Center Report, potentially will be of use to the Commission. The Cost Center Report, Submission Six in the Hospital Five-Year Plan, solicits information concerning the service area and expected utilization and capital and operating costs of thirty-one selected cost centers. The hospital is required to project cost center operating and capital expenses for the next five years, assuming no DON projects arise. The hospital is then required to project the impact of each Determination of Need project anticipated over the next five years on the level of activity and operating and capital expenses of the thirty-one cost centers. In the future, its DON program anticipates holding hospitals to those costs reported in the five-year plan. The Commission also plans to limit the level of reimbursement to those costs reported to the Determination of Need Program.

The Commission was also involved in the developmental work being coordinated by the OSHP in the area of standards and criteria. The Commission reports that major progress was made in such areas as Financial Standards and Criteria, Psychiatric Standards and Criteria, and Laboratory and Neonatal Intensive Care Units Standards and Criteria. All of the standards and criteria are eventually to be incorporated into the DON review process.

The Determination of Need application form was also revamped in 1978. The revised form is expected to provide the Commission with more detailed information on the impact of the financial structure and operations of the hospital.

The Commission has also worked with the OSHP on a proposal to create a Health Systems Development Fund (HSDF). Still in its early phases, the HSDF is essentially a project designed to encourage, "through the technical and financial resources of the state, the closure of unnecessary hospital facilities, the merger of discrete services and hospitals, and the conversion of costly facilities to different modes of care."[1] This project still appears to be in the planning stage. However, the results of this

[1]Massachusetts Rate Setting Commission, Annual Report, 1978.

project should have significant bearing on Commission policy. One of the MHA's primary complaints has been that the Commission does not allow costs associated with the merger of hospitals or discrete services as an automatic pass-through. The Commission, in support of its position, points to the lack of research that provides evidence of the cost savings of hospital mergers.

While the Commission and the Department of Public Health have worked together on a number of projects, more collaboration is necessary before moving to an integrated approach to rate setting. In general, the Commission has not had a major impact on the policies and direction of the DON program. Rather, it has served more as a source of technical assistance and information. The Commission, on the other hand, has clarified its position on reimbursement issues that relate to project applications and has agreed to be bound by DON decisions.[1] In the area of setting substantive standards for services, the Commission has set standards for CAT scanner services. It is in this area that the Commission will be able to exert more control on capital expenditures.

The Commissioner of Public Health, while highly supportive of Rate Setting Commission activities, also has been one of the major critics of the program. The position of the DPH has been that the Commission has failed to firmly administer controls on hospitals. The former commissioner was especially critical of the financial requirements methodology for its allowance of substantial hospital charge increases. The commissioner and the HPRB representative from Blue Cross agreed that hospitals should be made to cover deficits created by Medicaid through nonpatient revenues (i.e., endowments, etc.), maintaining that they have historically done so anyway. Those HPRB members who have not designated subordinates as members of the Board tend to be very vocal and active participants in the cost containment process, and the Commissioner of DPH tended to lead the "crusade" against the hospitals.

While the Commissioner of DPH has been critical of the Commission's lack of aggressiveness, substantial controversy has surrounded the harsh approach of the DPH in fulfilling its own regulatory functions. Moreover, there are joint efforts that might be undertaken by the Commission and DPH to tighten the program; however, these involve turf issues between agencies. One such issue would be the Commission's assuming responsibility for the financial analysis of DON projects. The recent change in administration once again opens the question of what direction future interactions between the Commission and DPH will follow.

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[1]Urban Systems, Draft Report, Massachusetts Determination of Need Program, 1978.

Department of Public Welfare

The Department of Public Welfare is the state agency responsible for administering the Massachusetts Medicaid plan. As the "single state authority," it alone has the authority to request changes to the state plan. This also means that the Rate Setting Commission's authority is limited, with respect to the Medicaid program, by the provisions of the federally approved state plan.

As in the case of the Department of Public Health, the Secretary of Human Services appointed the Commissioner of Public Welfare to sit on the HPRB; the position was delegated to the director of the state Medicaid program. With the exception of this linkage, there are few formal interactions between the audit manager of the Medicaid program and the Department of Public Welfare.

Although the Department of Public Welfare has not closed the door on participating in the 409 program, most consider its efforts to date to reflect little enthusiasm. There is no question that the definition of reasonable operating costs under the Medicaid system is substantially lower than that of 409. Should Medicaid join the 409 program as it is currently structured, the Medicaid budget would be subjected to a sharp short-term increase.

There is currently much speculation as to whether or not the Medicaid budget will be subjected to another sharp cutback given the new Governor's pledge to cut taxes by $500 million. The Department of Public Welfare reports that, should this be the case, the Medicaid program would cut back on hospital payments before eliminating Medicaid program services. There has been, however, some discussion of the possible conditions under which Medicaid would come under Chapter 409. It has been suggested that Medicaid might buy into the program if the uniform rate used is changed to reflect the Medicaid rate, which would mean a drastic shifting from the 409 prospective methodology to the prospective methodology used by the Medicaid program. Another approach might be to weight the 409 formula in some way, either by the Medicaid rate or by the availability of state funds.

Needless to say, this would create an uproar in the hospital industry; more than one hospital representative has said that hospitals could not survive under such a system. This situation merely highlights one conflict the new administration will have to resolve.

Commercial Insurors

Chapter 409 specifies that a representative of private insurance companies be represented on the Hospital Policy Review Board; John Hancock

currently represents this constituency. Of the fifteen percent of the market controlled by commercial insurors and self-payors, Hancock's share is relatively small.

The representative is not considered a vocal member of the group, and to date, has not influenced the direction of the Commission's policies. Blue Cross, in fact, has felt that the interests of private insurors have not been monitored closely enough. The reason for this may be twofold. To date, the private insurance companies, although acknowledging substantial charge increases, feel that they are still in a better position with charge control legislation than otherwise. Second, the technical nature of the methodologies employed by the Commission has precluded numerous individuals from assuming a more active role.

Health Systems Agencies

There are six health systems agencies in Massachusetts; all have received full designation. Of these agencies, two have been actively involved with the Rate Setting Commission. The largest HSA in Massachusetts represents the greater Boston area; the other, also a sophisticated agency, represents one of the more overbedded areas in the state. HSAs in Massachusetts, as in other states, are focusing their energies on excess bed capacity, mergers, capital equipment, and the development of standards and criteria. Massachusetts differs from many states in that the initiative for many of these activities has come from the Office of Health Planning and Development at the state level. Two of the six HSAs have addressed the financial and economic implications of services in their health systems plans, as well as specific linkages with the Rate Setting Commission.

HSAs are not involved in the actual process of setting rates for hospitals in the Medicaid program; HSA involvement in the charge control program is limited to their representation on the Hospital Policy Review Board. The Governor is required to appoint one "nonprovider" member of an HSA Governing Board. In that capacity, they participate in the review and comment of regulations promulgated for the charge control program. The only other formal interaction between the Commission and the health systems agencies has been through the federal project. To that end, HSA representatives have attended several meetings of the project's informal advisory board, but due to the technical nature of the work done to date, HSA input has been minimal.

Recall that the original legislation proposed by the Governor specifically outlined a role for the HSAs in the review process itself. Determining volume projections and conducting appropriateness reviews were the major areas in which the Commission and HSAs were to be interwoven. Given that this was not included in the final legislation, the interaction between these two groups has been more informal in nature.

Informal interactions between HSAs and the Commission range from data collection and special analyses to informal technical assistance. The Commission has a tremendous reservoir of information that is not published in any formal manner. HSAs call upon the Commission to provide them with data for planning purposes and have requested that information be published on some kind of annual basis. Upon request, the Commission will also conduct special analyses for an HSA. To date, these have included assessments of the financial viability of an institution showing chronic under utilization, determination of the economic impact of hospital mergers, and determination of the reimbursement effect of DON applications. The Commission has also conducted several educational meetings to explain changes in its methodologies, which have been attended by the planning community.

In summary, the Commission has begun to lay the framework for interweaving the rate-setting process with planning, but the initiative has primarily been at the state level. As the process currently exists, the lack of strong linkages between planning and rate setting weakens the entire cost containment system. The long-term picture does include a role for the HSAs; however, the nature of this role appears to be very much dependent upon the political environment that will emerge in Massachusetts over the next few years.

Labor Unions

Massachusetts, in comparison to states of similar size and sociodemographic characteristics, is not a highly unionized state. Given the large number of hospitals in the state, there has been relatively little union organization in other than public and city hospitals. It is estimated that there are 100,000 hospital employees, of which fewer than fifteen percent are unionized.

Nurses in the Massachusetts Nursing Association constitute the largest group of unionized employees, representing approximately 6000 to 8000 employees, including those in public hospitals. In addition, there are four AFL-affiliated unions and a few independent unions that operate in the suburban hospitals. With the exception of the Massachusetts Nursing Association, the Local 880 Hospital Employees Union Group is the largest union, having a membership of about 1500. This union group has been operational for six years but has not had the resources to mount a concentrated effort to enlarge its membership.

There are no formal interactions between the unions and the Commission. However, several policy issues have surfaced. The policy of Chapter 409 with regard to labor costs has been very explicit, and the results of arbitration or wage negotiations are not recognized as a cost beyond the control of the hospital. The small number of appeals to the 409 program attributable to union negotiations would seem to substantiate that union activity is somewhat limited.

The Medicaid program's policy on the reimbursement of antiunion activities of the hospitals has been an issue of controversy. The Massachusetts Hospital Workers Union filed a bill in the legislature that would bar Medicaid reimbursement for "any hospital expenditure to consultant firms or hospital employees whose primary job is to reject unionization." Specifically exempted under the bill are charges paid to lawyers or law firms representing a hospital in negotiations with a union before the labor board or giving limited advice on legal responsibilities under the National Labor Relations Act.[1]

The controlling regulation on this issue is RSC 71-33, S.3. For hospitals to receive Blue Cross and Medicaid reimbursement for consultant costs, they must provide audit staff with a statement providing data on the purpose, necessity, duration, benefits, and costs of the consultant services; and a copy of the consultant contract and report. There is no provision limiting the nature of the consultant activity.[2] The legislation did not pass in the last legislative session but has since been refiled. Passage of the bill is doubtful, however, as the union has limited resources to devote to lobbying for its passage.

Legislature

The Massachusetts state legislature is composed of two houses: a forty-member Senate and a 240-member House of Representatives. The Massachusetts Rate Setting Commission comes under the purview of the Joint Committee on Health Care. Established in 1975, this committee is responsible for reviewing and reporting on all health-related bills. Although the Committee consists of twenty-one members--seven state senators and fourteen state representatives--limited staff support precludes active involvement in any of the state's health care programs.[3]

Within Chapter 409 there are two provisions for legislative interaction with the Rate Setting Commission. The Hospital Policy Review is mandated to report at least annually "on its findings, opinions and recommendations" to the Governor and the legislature, with copies to the Joint Legislative Committee on Health Care. The other provision for interaction empowers the legislature to "determine the necessity of appointing an unbiased and competent third party to resolve disputes that may arise between the parties during mandatory development of the methodology." The Joint Health Care Committee also has the power of post audit and oversight investigation of Commission activities; however, it does not have the personnel to implement this activity.

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[1]House Bill 2889.

[2]Massachusetts Rate Setting Commission Memorandum, April 6, 1978.

[3]Urban Systems, Draft Case Study, Massachusetts Determination of Need Program, 1978.

Although there are several formal mechanisms for interaction between the Commission and the legislature, there has been virtually no interaction since the passage of Chapter 409. Recent events, however, indicate that this situation may soon be changing. The 1978 elections resulted in a new Governor and Senate committee chairman; several legislators have retired and/or moved from one house to another, leaving a skeleton health committee with no leadership. It is too early to predict the effects of the new administration and committee composition. However, the outcome of several key legislative amendments filed by both the Commission and the MHA should reveal how the Commission fits into the Governor's overall political strategy.

PRELIMINARY ASSESSMENT

So far, the information in this case study has been for the most part descriptive in nature. In this section, several aspects of the Massachusetts system are assessed in a preliminary manner: structure, process, system incentives, and equity. Throughout the discussion, the Medicaid and 409 systems are contrasted along these characteristics. Table 5 contrasts the two systems on key characteristics. It should be noted that the comments contained in this section in no way represent a definitive assessment.

Structure

To review the structure of the Rate Setting Commission, it is located within the Executive Office of the Secretary of Human Services, an umbrella agency that includes the Departments of Public Welfare, Public Health, and Mental Health and numerous other agencies. Both rate-setting programs are administered by the Bureau of Hospitals, one of the four bureaus of the Commission. Both the 409 program and Medicaid are bound by the state's fiscal pressures; the Medicaid system in particular is dictated by the state budget. Having both programs located within the Human Services Agency poses somewhat of a dilemma for the Secretary of Human Services. On the one hand, the secretary, through the Medicaid program, has had to constrain the tremendous growth in the Medicaid budget. On the other hand, the Commission is administering a charge control program, which has as its goal full payor participation. A delicate balance must be reached before both systems are ever merged. To date, the former Secretary of Human Services had only been willing to "consider the possibility" of merger but with the appointment of a new Secretary of Human Services, this question is again open for discussion.

The difficulties of the current organizational structure of the regulatory agencies within the Commonwealth have prompted the development of a plan for reorganization. The plan is still in the very preliminary stages of discussion. Thus, in terms of its location within the state bureaucracy, the Commission remains subject to the constraints imposed by the political and fiscal environment of the state.

TABLE 5: Massachusetts Rate Setting Systems: 1978 (FY 1979)

CHARACTERISTIC	409	MEDICAID
Type of system	Mandatory/formulary and budget review	Mandatory/formulary
Unit of approval	Net patient services revenue and charges as they generate appropriate revenue	Per diem rate
Screens	Inflation, volume, costs beyond control	Inflation, administrative adjustments
Base year	Two years prior to budget year	Two years prior to budget year, but limited by actual costs of the prior year, plus inflation adjustment
Allowable costs	Includes a provision for bad debt and free care; replacement value depreciation on major movable equipment	No provision for bad debt and free care. Historical cost depreciation used on major movable equipment
Compliance	None - FY 1980 will have a method for determining reasonableness of base-year costs	None - but may reset per diem rate to reflect results of audited data.
Groupings	None - scheduled for FY 1980	Teaching/nonteaching hospital grouping used only to determine appropriate occupancy rates
Penalties	None	The higher of available days in the base year or the percentage of actual days in the base year
Length-of-stay penalty	None	None
Uniform reporting	First implemented FY 1979; full data set available FY 1981	Since 1968 - HCF 400 forms replaced by 401 forms in 1975
Scope of Coverage	15 percent hospital expenses: commercial and self-payor	15 percent hospital expenses: publicly assisted patients

Another consideration when assessing the structure of the Commission is its intraorganizational structure. Unlike many rate-setting authorities, the Commission has responsibility for four separate bureaus; the three commissioners split their time among each of the bureaus. Although the original thought was that the combined program format would result in better coordination and possibly some cost savings, the consensus is that there have been few economies of scale gained. The methodologies and issues of the hospital bureau are unique and do not cut across bureaus. Furthermore, staff are not easily interchanged among bureaus. The largest savings has been having the Medicaid and Blue Cross audit team within the Bureau of Hospitals.

There is another aspect of the organization and administration of the two programs that must be considered. As can be seen in Table 5, the two systems are different; they are managed by separate staff, operate on different timetables, and must comply with separate regulations. The Commission tries to emphasize that there are two programs, each having different mandates and pressures. This is true, in that the pressure to limit costs under the Medicaid system is far more severe than that of the 409 program; however, hospitals generally do not divorce the two systems from one another. The continuing cutbacks in the Medicaid rates have definitely eroded some of the credibility the 409 program has attempted to establish because 409 has had to increase charges to cover the Medicaid deficit.

Process

In this section, the rigor of the two systems is scrutinized by examining several aspects of the process used by both 409 and Medicaid. Chapter 409 is a combined formulary budget review and charge approval system. The Medicaid system also uses a formulary method and approves a per diem rate. In Massachusetts, both systems limit the involvement of hospitals in the setting of rates. For the Medicaid system in particular, hospital involvement in the rate-setting process is limited to the appeal process. Hospitals charge the Medicaid program with ignoring the individual characteristics of hospitals--i.e., the nature and intensity of care given--a situation intensified by the Boston teaching hospitals, whose expenses are much higher as compared to those for the suburban community hospitals. However, the Medicaid program does distinguish between teaching and nonteaching hospitals in determining appropriate occupancy rates. Furthermore, recent changes in the 409 methodology have benefited hospitals with high Medicaid populations; and the 409 methodology determines allowable net patient service revenue according to individual hospital cost structures.

Third-Party Payors Covered

Although Massachusetts has two prospective systems, they only represent approximately thirty percent of the patient population of a given hospital.

Each of the cost-based payors--Blue Cross, Medicare, and Medicaid--imposes a "lower of cost or charges" limitation. The Commission contends that its 409 program as of FY 1979 sets an implicit limit on the amount that third-party payors reimburse. The rationale behind this is that a hospital cannot earn more than the allowed net revenue approved by the Commission; however, without some form of compliance, this argument is not very convincing. The Commission currently does not have a methodology for assessing the reasonableness of base-year costs and has no formal mechanism to recoup excess revenue--with the exception of filing charges in court, a mechanism that is considered rather excessive and costly in light of the goals of the program.

As indicated previously, involvement of the remaining third-party payors is still an open question. The Commission is looking toward FY 1981 for full payor participation. Given the recent change in administration, it is difficult to assess the outcome of this situation. The consensus at the present time is that Medicaid will not be able to join the 409 system as currently conceived because it would not be able to absorb its full share of costs. Blue Cross is playing a waiting game with this issue and conducting its own assessment of how well the system is functioning. While Blue Cross has no incentive to join the system, it has every reason to encourage any state-run hospital containment program since Blue Cross, as a cost-reimburser, directly benefits. It is likely that Medicaid and Blue Cross would participate only if certain conditions were satisfied.

The Payment Unit

The Commission currently has the authority under Chapter 409 to approve an aggregate amount of revenue equaling total patient care costs and charges. (In the past its authority was limited to approving charges.) The hospital is then allowed to establish any schedule of standard charges which should produce no more than the approved amount of revenue.

One of the real weaknesses in the system has been the application of the Commission's authority to approve charges. The process of deriving a hospital's total allowable revenue is fairly straightforward, but moving from total revenue to charges has been described as a "leap of faith." The Commission is limited in its ability to determine whether or not the total amount of revenue a hospital projects is equivalent to the individual charges set. There is more confidence in the area of routine charges such as room and board; ancillary services, such as lab and x-ray, are more problematic. Commission staff are aware that hospitals have, without increasing their volume, earned additional revenue by setting their approved charges higher than actually needed in case projected levels of volume are not experienced. If they do experience or exceed expected levels of volume, extra revenue is generated. The hospital is in essence allowing itself a margin for error. If the system included a compliance provision, the hospital would merely refund the money after having

use of it for the year. The incentive, then, is to budget as high as the formula allows, since unanticipated losses cannot be recovered in later years. If approved revenue levels are not earned at the outset, the lower cost level will be used as the base year. In other words, the incentive is to generate at least as much revenue as approved in the budget year, since this year becomes the base year. The Commission to date has not seriously considered changing the payment unit used in the system. Chapter 409 limits the Commission to controlling revenue accrued to charge-based patients only.

In the case of the Medicaid system, the reimbursement methodology results in prospective inpatient and well-newborn per diem rates, which are all-inclusive regardless of the type of services delivered, surgical procedures undertaken, or ancillary services provided. The inpatient per diem is computed by dividing total projected allowable inpatient costs by total allowable inpatient days. As with the approval of charges, the incentive for the hospital under this payment unit is to increase both admissions and length of stay when marginal revenue is greater than marginal cost.

Definition of Rate Base

The Commission began using a two-year base under the 409 program in FY 1978 (1977); prior to that, a one-year base was used. The Commission clearly benefits in using a two-year base by achieving a greater degree of accuracy in its base-year data (base year and intermediate year). As currently structured, the 409 program has no method for determining reasonability of base-year costs. The weakness of 409 is the Medicaid system's strength; the Medicaid program uses a two-year base, which is limited by costs of the year prior rolled forward for inflation. In effect, the base year is three years old. Also, the Medicaid program has the authority to verify base-year costs through the replacement of unaudited data with audited data. An additional facet of the regulations allows the Commission to go back and adjust the per diem rate if the inflation factor applied to the base year is substantially at variance with actual inflation experienced.

Allowable Costs

Both systems use Medicare cost categories to derive base-year costs. The Medicaid system, however, is by far more strict in its definition of allowable increases than 409 and Blue Cross. Nonoperating allowable costs include all depreciation, interest expenses, rental payments, property taxes, and legal fees. The Medicare routine per diem limit is used for the limit on the Medicaid administrative day rate, as well as the all-inclusive per diem rate. Inpatient days are adjusted by medical/surgical, maternity, and pediatric inpatient days. The higher of actual days or a set percentage of available days in the base year is accepted.

The 409 program is more generous in its definition of allowable increases in costs. These include direct patient care cost--salaries,

wages, insurance, supplies, expenses, maintenance, taxes, cost of education, hospital-based physician compensation, new services, volume adjustments, inflation adjustments, and "costs beyond control"--as incremental operating costs. During fiscal year 1979 the Commission began to reconsider its full recognition of all of these costs, as well as the use of nonpatient revenues to offset costs. For instance, Chapter 409 currently recognizes the full educational costs of hospitals. The Commission has left the door open to further refining its definition of allowable costs in FY 1980, and educational costs will certainly have a high priority in the future.

The Massachusetts legislature has recently amended the Determination of Need statute to exempt changes of service related to research or education projects. If the hospital can certify that the project will not increase total patient care charges under Chapter 409, this will be an important area for the Commission to investigate.

In the area of new services, the Commission has begun to move toward a tighter control. Past policy was to define a new service as any activity generating a new charge to increase either costs or revenues by $50,000 or more. New services were in essence allowed the entire budgeted costs. Clearly, the incentive has been to generate new services when it appeared that a particular cost center's budget would exceed the incremental limitations imposed on base-year costs. Chapter 409 program staff found that new services ranged from an intensification of existing services, or an additional subspecialty, to startup of a new department.

For FY 1979, the Commission required that new services be segregated as new cost centers, as specified by the Hospital Uniform Reporting Manual. New charges within cost centers were not recognized; the costs associated with these new charges must be accounted for through the volume adjustment or through a determination of need, which is considered a pass-through. The new policy also sought to limit the extent of subsidization allowed by creating new services. In the first year, the maximum patient service revenue is reduced by fifty percent of the new service deficit for a new service started in the intermediate year and by 100 percent for a service started in the base year.

The Commission introduced a capital budget for FY 1979; previously, interest and historical cost depreciation were included in the operating budget. In the area of major movable equipment, the Commission is considering this an ongoing expense. A goal of the Commission is "to encourage primarily internal financing of major movable equipment expenditures from current cash flows available and funded depreciation." Although the Commission considered moving from historical cost depreciation plus interest to cash needs for expenditures, debt service, and future funding, the hospital industry lobbied strongly against such a move. Thus, for FY 1979, the Commission continued to use historical cost depreciation plus long-term

debt interest as the basis for determining building and fixed allowances. That is, they allowed replacement value depreciation for major movables but not for building and fixed allowances.

Volume

Medicaid applies the most stringent restrictions for volume adjustments, which are not considered in total rate-year cost figures. While Medicaid does employ occupancy penalties, the system does not, however, control for sharp increases in patient days or visits. Chapter 409, on the other hand, uses a cost formula to discourage large volume increases and decreases. The Commission recognizes full unit cost for volume increases and decreases that fall within the volume corridors of three and five percent, respectively. Chapter 409 also automatically allows a variable cost increase of forty percent if the hospital goes beyond the established corridors. Although this is considered rather generous, it is still capped, as mentioned previously, by application of the formula.

The volume adjustment in 409 is one of the weakest aspects of the system. The Commission relies on hospital projections of volume, and does not consider area volume changes, community utilization statistics, or length of stay. The MHA has voiced numerous objections to the use of patient days to measure volume, contending that there are statistics available on an annual basis for establishing volume statistics in ancillary service departments. The Commission is still at the research stage in resolving this issue.

Inflation

Both the Medicaid system and 409 use a weighted average inflation factor, with weights derived from hospital data multiplied by published and forecast inflation indicators for various cost categories. The systems do differ as to the manner in which the weights are derived, the cost categories that are used, and the years for which inflation is applied.

Chapter 409 applies a unique inflation factor to each hospital based on weights determined from the costs of the individual hospital. Medicaid applies only one inflation factor to all hospitals; thus weights are calculated from aggregate data. Therefore, hospitals with high proportions of costs in high inflation categories do not do as well under the Medicaid inflation adjustment.

Under both systems, the inflation factor is applied only to operating costs for FY 1979. During this year, inflation was not allowed on depreciation, interest, bad debt, and free care. Both systems use indices that are external to the industry, a practice that has raised serious objections from hospitals, especially in the area of salaries. The Association's general position is that the methodologies and proxies being used are not responsive

to inflationary pressures on hospital cost factors in general. More specifically, the Association contends that the cost adjustments used do not allow any flexibility in union negotiations, nor do they allow hospitals to establish parity within the labor market or among groups of employees within hospitals.

The Commission's response to this has been firm: it will not adjust the labor inflation factor for wage negotiations because the Commission would then become a "pay board," and any incentive for management to be firm with negotiators would be undermined. Although the Commission's policy is definitely a rigorous one, especially when compared to the Blue Cross contract, it should be noted that the 409 inflation factor is unique to each hospital. Thus, although the inflation indices are external to the hospital industry, the hospital could, through internal management, apply different and more appropriate inflation factors to different line items; the control factor is the composite index, not the individual indices. Medicaid's policy on labor has also been the subject of dispute; this time, however, with the unions. Medicaid policy recognizes consultant costs, including those used for antiunion activities.[1] This policy is currently being challenged by the unions. Rather than using the court process, however, unions have unsuccessfully filed several legislative amendments.

The last major adjustment common to both the Medicaid system and 409 is the administrative adjustment for costs beyond the control of the hospital. (These have been discussed in detail in the section on screens.) These adjustments generate the most controversy in both programs because some degree of negotiation enters into the system; that is, a straight formula approach is not used.

In the Medicaid system, the area of administrative adjustments is not as highly specified as are other parts of the system. While there are specific situations defined for which a hospital may apply, the regulations do not include anything that points to how the calculation will be made; this essentially is decided by the Medicaid audit manager. In other words, he decides the extent of documentation necessary and the maximum allowable adjustment to be obtained.

The 409 cost beyond the control of the hospital has provoked much disagreement between hospitals and the Commission. Key controversial issues include the following:

- Hospitals have the burden of demonstrating that each requested CBC is not included within the allowed operating cost and inflation and volume adjustments.

[1]These costs are also recognized under the 409 system.

Hospitals find this an "impossible burden" in that every hospital cost is included in every cost category for inflation.

- Hospitals have to wait until they are found to be in violation of federal or state standards before the costs of meeting these standards will be allowed. For instance, 409 regulations specify that Joint Commission on the Accreditation of Hospitals (JCAH) reports that merely "recommend" improvements will not be considered a cost beyond the control of a hospital.

- The 409 regulations do not sufficiently address increased costs due to improvements in medical practice or technology.

Hospitals also contend that both systems penalize the hospital that is successful in its cost reduction efforts. This is, in fact, a negative incentive because 409's methodology caps budget-year allowable costs by rolling forward the lower of actual or budgeted base- and intermediate-year costs. Medicaid has a similar but more austere formula, which actually includes data for three years prior to the rate year.

System Equity

Extent of Due Process

Both systems have formal mechanisms for appealing a rate or decision. The appeal concerns only the application of a regulation, not the regulation itself or the equity of a rate. In other words, if the hospital cannot prove (and the burden of proof lies with the hospital) that a regulation was incorrectly applied, the case is lost. There are limited opportunities for the hospitals to have input to the development of regulations: the mandated consultation process, public hearings, and appeal to the Hospital Policy Review Board. The HPRB, as mentioned previously, tends to be either ineffective or unsympathetic to the industry. The inability of the hospitals to have significant input to the formulation of regulations or some control over their application may seem to be a strength of the system. However, it may in the end have a damaging effect by forcing hospitals to bypass the Commission and go directly to the legislature. This has happened with the Massachusetts DON program, and hospitals were successful in two attempts. Thus, the rate-setting process may be undermined in the same manner as was the DON process.

Ambiguity in the Rate-Setting Process

The legislative foundation for the Massachusetts 409 program does not provide the Commission with sufficient authority in several key areas. The

most outstanding example of this is the lack of authority to conduct compliance review. On the other hand, the legislation does provide considerable authority to the Commission, through regulation, to interpret and define the methodologies specified in the law. For instance, the law specifies that charge increases must be consistent with the rate of inflation in the economy generally. The Commission, although mandated to use a composite inflation index, may specify the indices to be used through promulgated regulation. In the area of volume adjustments, the legislation is vague and authorizes the Commission to develop a methodology to determine increases allowed due to volume changes. Even in the area of costs beyond reasonable control (CBCs), the legislation offers no definition. Hospitals have had to concentrate on the wording of the legislation that includes "costs beyond the control of the individual hospital" in order to argue their cases. The Commission, through regulation, has been able to severely limit instances considered to be costs beyond the control of the hospital.

Changes to be incorporated in the 409 methodology are defined, as are dates of implementation. The legislation is clear in the approach the Commission must take; i.e., moving to approval of total net revenue which must equal the reasonable financial requirements of the hospital; however, definitions and specification of the exact methodologies are established through regulation.

As the Commission moves to further define reasonable financial requirements, it has also been confronted with conflicting objectives embodied within the legislation: that of controlling excessive rates of increases versus providing for a hospital's reasonable financial requirements. A delicate balance must be found. Furthermore, the Commission's authority to use other sources of income to offset patient care charges is being challenged by MHA as reaching far beyond the scope of Chapter 409. As worded now, the legislation would seem to allow the Commission to adopt definitions of "total patient care charges which reflect actual revenue received by the hospital for all patient care services, supplies and accommodations."[1]

The legislation further calls for the Commission to adopt, by October 1, 1979, a methodology for reasonably grouping hospitals by any or all of the following criteria: size, services, department, and other appropriate criteria. This mandate, already meeting resistance from the industry, is also ambiguous in its language. The question of whether the grouping methodology becomes the sole criterion for approving charge modifications is still to be resolved.

Regulations

Regulations promulgated under Chapter 409 are detailed, formalistic, cumbersome, and often described as "burdensome." The regulations contain

[1]Emphasis added.

the methodology to be used in the budget review and all forms that are to be used in the review process. Once regulations are promulgated, there is very little discretion left to the analyst or the commissioners.

Regulations have tended to be promulgated on an emergency basis for several reasons. The provision for review and comment required by law leaves a short time frame for development of methodologies and appropriate review; last-minute changes in the methodology thus end up as emergency regulations. Emergency regulations stay in effect for ninety days and must be followed by a public hearing.

Key concerns that have been voiced by both hospitals and Commission staff concern the administrative burden imposed by the level of detail and complexity of the regulations and the use of emergency regulations. The budget package that hospitals must fill out is indeed voluminous. However, it may serve as a useful management tool for hospitals. The use of emergency regulation has been a problem for several years, and the combined task of developing the methodologies for the 409 system and promulgating regulations to reflect these methodologies has been the cause of this problem. There is no evidence to suggest that use of emergency regulations has been deliberate. Because the regulations are so detailed, they generally contain all key operating procedures of the Commission, thus limiting any ad hoc treatment of hospitals.

Extent of Cross-Subsidization

The Massachusetts program controls a very small part of the total patient days in the state. Medicaid accounts for approximately fifteen percent, and commercial and self-pay patients account for an additional fifteen percent. Blue Cross's share is thirty-five percent. Although the self-pay patients and commercial payors are under a charge control system, this group is still subsidizing the costs of payors who pay less than cost--mainly Medicaid. The 409 program, in meeting the financial requirements of the hospital, in essence allows the hospital to recover at least a portion of those costs disallowed in Medicaid and Medicare. Blue Cross, because of its more generous cost limitation provisions, also allows hospitals to recover costs not allowed by either Medicaid or 409. For instance, Blue Cross is more generous in that it allows replacement value depreciation on buildings and fixed equipment.

Perhaps the strongest charge lodged against the Commission is that it has assured the subsidization of the Medicaid program by other payors, who have already paid for it once through taxes. The hospital industry contends that "the Commonwealth, acting through the Commission, is using the Chapter 409 system to levy a hidden tax on health insurance premiums and charge-paying patients." Chapter 409, according to industry spokesmen, is being used "for the political expediency of balancing the budget by shifting the

burden to insurance premiums." This is a charge that the Commission is having difficulty denying. The new 409 methodology implicitly mandates the subsidization of the Medicaid program as long as the Medicaid program reimburses less than costs.

A summarization of the strengths and weaknesses of the 409 and the Medicaid systems are presented in Tables 6 and 7, respectively.

FUTURE DEVELOPMENTS

Developmental Work[1]

As discussed previously, the Commission has had a developmental contract from the Health Care Financing Administration since 1976. The research conducted to date has resulted in revisions to the inflation index, a uniform reporting manual, the definition of standards for CAT scanner services, and a more integrated approach to collecting data to be used in evaluating capital expenditures through the Determination of Need program.

Fiscal year 1980 promises additional changes in the 409 program. The first change involves development of a methodology to determine volume adjustments. The Commission has proposed a substantially different methodology in which volume adjustments would be performed separately, based solely on direct costs, for all overhead and revenue-producing cost centers. The Commission is also considering eliminating the current three- and five-percent volume corridors, applying instead a variable cost percentage to all increases or decreases in volume. This change would establish departmental variable cost percentages.

Another change under consideration by the Commission involves a more sophisticated test of the reasonableness of volume forecasts submitted by hospitals. A quantitative model designed to evaluate changes in patient days, admissions, general measures of activities, and changes in the volume of ancillary services is currently under development. As presently conceived, this evaluation would consider both internal and external volume factors.

The lack of a technique to evaluate the reasonableness of base-year costs has been a considerable constraint on the 409 program. However, the Commission does not have the authority to implement such a methodology until FY 1980, at which time it is anticipated that base-year costs will be assessed using a grouping methodology designed to incorporate interhospital comparisons.

The task of extensively reviewing budgets for all hospitals is a time consuming process. The Commission is considering introducing a limited

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[1]Massachusetts Rate Setting Commission, Issue Paper, March 8, 1979.

TABLE 6: Strengths and Weaknesses of Chapter 409 (1978/FY 1979)

Strengths	Weaknesses
• Formula places cap on budget-year revenues	• No methodology to assess reasonable base-year cost
• External inflation indices responsive to general economy	• No compliance review
• Costs associated with volume above or below established corridors limited to forty percent base-year unit cost, adjusted for inflation	• No methodology to assess reasonableness and accuracy of volume projections
• Specific definition of costs beyond control of hospital limits negotiation over allowable revenue	• No groupings/interhospital comparisons
• Methodology provides incentive for hospital to reduce costs to obtain greater margin between costs and approved revenue	• Lack of full payor participation leads to subsidization of public assistance program
	• Costs associated with Determination of Need projects considered pass-throughs
	• Controls only incremental cost increases

Table 7: Strengths and Weaknesses of Medicaid (1978/FY 1979)

Strengths	Weaknesses
• Formula caps rate-year costs.	• No adjustment for length of stay
• Use of Medicare inpatient[1] day routine cap	• No groupings/interhospital comparisons
• Use of three-year data to cap base-year costs	• Controls only incremental cost increases
• Occupancy penalty	• Severely tied to constraints determined by state Medicaid budget
• Use of Medicare definition of allowable cost	• Costs associated with Determination of Need projects considered pass-throughs[2]
• Audit mechanism that controls allowability of base-year costs	
• Administrative review mechanism allows Commission to review rates and adjust if necessary	

[1]Required by federal law.

[2]This could be considered a strength if the DON applicant withstood a tough financial analysis.

review for FY 1980; a budgetary screen based on projected price increase would be established. If a hospital fell below the screen and did not experience cost disallowances in the grouping analysis used, the hospital would be eligible for a substantially reduced filing requirement, as well as a limited review by the Commission.

Yet another change being considered by the Commission is that of full payor participation. As mentioned previously, full payor participation is a long-term objective of the Rate Setting Commission. Therefore the Commission is continuing its work in the area of analyzing and evaluating changes required for full participation by FY 1981.

Some of these proposed changes are designed to fulfill the legislative mandate of the 409 system, while others strive to improve the effectiveness of the current system. Prior to implementation of any of these changes, the Commission must consult with representatives of Blue Cross, the Massachusetts Hospital Association, and the HSAs. The proposed changes must also be reviewed by the Hospital Policy Review Board before regulations are promulgated. Once regulations are issued, public hearings must be held. Thus, the extent and nature of the changes proposed are still unknown at this time, although it is clear that several legislative amendments currently under consideration could limit the nature of the proposed changes to the 409 program.

Legislation

The Commission will have had to wage several legislative battles during the 1979 Legislative Session. The first issue is self-initiated: the Commission has filed legislation to restore its authority to engage in compliance review.[1] However, this bill was not supported by the Joint Legislative Committee on Health Care. At this early stage, it does not appear that the Commission has mobilized the political support necessary to broaden its authority. The Commission's Hospital Policy Review Board has supported the Commission's efforts in this area, and Blue Cross would also be expected to play some role in supporting the legislation. Regulations that further repress hospital costs may bring hospitals up to the level of charges for Blue Cross payment purposes. From the Commission's perspective, this would damage Blue Cross's competitive position and act as a disincentive for hospitals to contract with Blue Cross. When this legislation was first considered, the president of Blue Cross actively supported this initiative,[2] and private insurors would also be expected to be in support of the legislative approach, although this piece of legislation is not anticipated to engender active consumer interest.

The Massachusetts Hospital Association has been in a peculiar position with regard to this issue. The Commission reports that MHA originally worked

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[1]Recall that the court struck down the Commission's regulations on compliance.

[2]Massachusetts Rate Setting Commission Memorandum, July 27, 1977.

closely with the staff in developing the compliance provisions but was not party to the litigation. It is also sensitive to the possibility that tighter cost controls may undercut hospitals' incentives to contract with Blue Cross. Should this happen, the MHA could lose certain leverage and benefits that it derives from the Blue Cross contract.[1]

On the other hand, hospitals have been incensed about the possibility of the Commission's tapping nonpatient revenues. MHA considers this an intrusion on the internal management of the hospital and the role of the board of directors and trustees. Legislation has been filed to limit Commission authority in this area. Thus, the Commission is expected to be embroiled in several key legislative issues, whose outcomes have definite implications for the future. Each of the bills filed by the MHA has been designed to undercut the effectiveness of Chapter 409. Briefly, two of the bills would limit the Commission's authority to implement the uniform reporting requirement until a federal uniform reporting system was developed, and would severely hamper the Commission's efforts to implement its grouping and cost comparison methodologies.[2] The third bill would limit the Commission from considering the following sources of revenue in its review and approval of hospital budgets and charges: restricted and unrestricted grants, gifts, contributions, bequests, fund principle and endowment balances, any income accrued from these funds, and any other income not related to patient care.[3]

The resolution of the issues faced by the Commission in the upcoming fiscal year will be highly dependent on the approach that the new administration takes to resolve the state's political and fiscal pressures. The former administration placed the Commission high among its priorities; the position of the new administration, elected with strong support from the industry, is currently unknown.

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[1]Massachusetts Rate Setting Commission Memorandum, July 27, 1977.

[2]The Joint Legislative Committee on Health in April 1979 rejected both bills.

[3]This bill, however, was supported by the Committee.

APPENDIX A

COST CATEGORIES AND ECONOMIC CHANGE INDICATORS

EXHIBIT I
REVISED COST CATEGORIES AND ECONOMIC CHANGE INDICATORS

Cost Category	Title	Definition	Economic Change Indicator	Source	Definition/Explanation
CC(1)	Professional/Managerial Salaries, Wages, and Fees	Salaries, wages, and fees for all physicians, residents, interns, directors of nursing, assistant directors of nursing, and other managerial personnel, such as administrators, controllers, personnel directors, department heads, and assistant department heads.	I(1)	Bureau of Labor Statistics (BLS); National Survey of Professional, Administrative, Technical, and Clerical Pay (PAT) and the Employment Cost Index (ECI)	The aggregate percentage change in the average annual salaries of the following PAT occupations, adjusted by ECI data for the Northeast Region: Attorneys, Highest Level Chemists, Highest Level Engineers, Highest Level Chief Accountants, Highest Level Personnel Directors, Highest Level
CC(2)	Nursing Salaries and Wages	All nursing salaries and wages not included in CC(1), above, excluding nurse's aides.	I(2)	BLS/PAT/ECI	The aggregate percentage change in the average annual salaries of the following PAT occupations, adjusted by ECI data for the Northeast Region: Attorneys, Level II Chemists, Level III Engineers, Level II Accountants, Level III Personnel Directors, Level I
CC(3)	Skilled Employee Salaries and Wages	Salaries and wages for all non-supervisory therapists, social workers, dietitians, technicians, and other skilled employees, such as accountants and computer programmers/analysts.	I(3)	BLS/PAT/ECI	The aggregate percentage change in the average annual salaries of the following PAT occupations, adjusted by ECI data for the Northeast Region: Chemists, Level II Accountants, Level II Engineering Technicians, Level III Job Analysts, Level II Draftsmen, Level II
CC(4)	Other Employee Salaries and Wages	Salaries and wages for all other employees not included in CC(1), CC(2), or CC(3), above.	I(4)	BLS/Employment and Earnings	The percentage change in the average hourly earnings of non-supervisory workers in the private sector, Massachusetts.
CC(5)	Fringe Benefits	"Fringe" benefit costs, including hospitalization insurance, workmen's compensation, employee group insurance, social security taxes, annuity premiums, past service benefits, pensions, and any other costs incurred for the direct benefit of the employees.	I(5)	Survey of Current Business, Department of Commerce	The percentage change in Other Supplements to Income, National Income Accounts, Massachusetts, appropriately adjusted to reflect Massachusetts employment levels.
CC(6)	Food	The cost of all foodstuffs used in the hospital, including the fair market value of donated (and used) food.	I(6)	BLS/Consumer Price Index (CPI)	The percentage change in the Boston CPI, Food at Home or the Hartford-Springfield CPI, Food at Home.

EXHIBIT I (Cont'd)

Cost Category	Title	Definition	Economic Change Indicator	Source	Definition/Explanation
CC(7)	Drugs and Pharmaceuticals	The cost of all drugs and pharmaceuticals dispensed from the hospital pharmacy, outpatient, or emergency departments. The cost of prescriptions purchased from an outside pharmacy should be accounted for in CC(13), below.	I(7)	BLS/Wholesale Price Index and Price Indices (WPI)	The percentage change in the WPI, Chemicals and Allied Products
CC(8)	Films and Photographic Supplies	The cost of all films and photographic supplies used in the hospital.	I(8)	BLS/WPI	The percentage change in the WPI, Photographic Supplies
CC(9)	General Supplies	The cost of all supplies not accounted for in the preceding three categories.	I(9)	BLS/WPI	The percentage change in the WPI, Industrial Commodities, less the following groups: fuel, machinery and equipment, furniture and household durables, transportation equipment, and miscellaneous products.
CC(10)	Electricity	The cost of purchased electricity, as billed by the electric utility.	I(10)	BLS/WPI	The percentage change in the WPI; Commercial Power (40 kw demand) or Industrial Power (500 kw demand), New England, depending on individual hospital use.
CC(11)	Gas	The cost of purchased gas, as billed by the gas utility.	I(11)	BLS/WPI	The percentage change in the WPI, Gas, natural.
CC(12)	Petroleum	The cost of petroleum, as billed by the petroleum supplier(s).	I(12)	BLS/WPI	The percentage change in the WPI; Middle Distillate (Fuel Oil No. 2 to Reseller) or Residual Fuels (Cargo Shipments to Resellers), depending on individual hospital use.
CC(13)	Services Purchased From Outside Organizations	The cost of all services purchased from outside organizations, including, but not limited to, accounting and auditing fees; data processing services (excluding computer leasing); collection fees; legal fees and expenses; all maintenance and repairs made by outside concerns to hospital facilities, grounds, or equipment; catering services, housekeeping services; telephone/telegraph services; laundry and linen services; the cost of prescriptions purchased from an outside pharmacy; fees of outside laboratories for pathological and other laboratory services; and so forth.	I(13)	BLS/CPI	The percentage change in the Boston CPI, Services less rent and medical care
CC(14)	Leased Equipment	Total equipment leasing/rental expense, including rental for general intercommunicating and paging systems.	I(14)	Marshall and Swift Publishing Co.	The percentage change in the Marshall & Swift index for hospital equipment
CC(15)	Short-Term Interest	Short-term interest expense, excluding mortgage interest and interest on long term debt.	I(15)	Survey of Current Business, Department of Commerce	The percentage change in the interest rate on short term business loans, 7 other North east centers
CC(16)	Costs Not Elsewhere Categorized	Reimbursable costs not included in any of the preceding 15 categories.	I(16)	BLS/CPI	The percentage change in the Boston CPI, Other Goods and Services

APPENDIX B

SUMMARY SCHEDULES

Exhibit B-1

_____HOSPITAL

For Budget Year Ended _____ A-1.0

SUMMARY SCHEDULE

	(1)	(2)	(3)
		BUDGET	RSC STAFF ADJUSTED
1	Working Capital Requirement (Sch.D-1.0,L.8)		
2	Capital Requirement (Sch.E-1.0,L.5)		
3	Operating Requirement (Sch.F-2.0,L.14)		
4	REASONABLE FINANCIAL REQUIREMENTS (L.1 + L.2 + L.3)		
5	Less: Cost Based Payor Reimbursement (Sch.A-4.0,L.11,C.4)		
6	Financial Requirements To Be Met By Self-Pay and PA Outpatient (L.4 - L.5)		
7	Self-Pay and PA Outpatient Mix (Sch.A-3.0,L.9)		
8	Maximum Gross Patient Service Revenue L.6 ÷ L.7)		
9	Requested Gross Patient Service Revenue (B-1.0,L.5)		
10	GROSS PATIENT SERVICE REVENUE (Lower of L.8 or L.9)		
11	Less: Contractual Adjustments (Sch.A-2.0,L.39,C.6)		
12	Less: Provision for Bad Debt and Free Care (Sch.A-5.0,L.16,C.4) x L.10 _____%		
13	NET PATIENT SERVICE REVENUE; TOTAL PATIENT CARE CHARGES (L.10 - L.11 - L.12)		

Exhibit B-1
(continued)

_____HOSPITAL

A-1.1

For Budget Year Ended _____

REVENUE ADJUSTMENT FOR NEW SERVICE DEFICIT

		(1)	(2)
COMPLETE ONLY IF NEW SERVICE DEFICIT EXISTS (Sch.O-1.0,L.16)			
1		New Service Deficit (at net) (Sch. O-1.0,L.16)	
2		Gross Patient Service Revenues before Adjustment (Sch. A-1.0,L.10)	
3		Net Patient Service Revenues before Adjustment (Sch.A-1.0,L.13)	
4		Ratio of Gross to Net (L.2 ÷ L.3)	
5		New Service Deficit (at gross) (L.1 X L.4)	
		ADJUSTMENT	
6		New Service Started in Budget Year Adjustment	0
		New Service Started in Intermediate Year	
7		Adjustment to Net (L. 1 X 50%)	
8		Adjustment to Gross (L.1 X 50%)	
		New Service Started in Base Year	
9		Adjustment to Net (L.1)	
10		Adjustment to Gross (L.5)	
11		ADJUSTED NET PATIENT SERVICE REVENUE (L.3 - L.7 - L.9)	
12		ADJUSTED GROSS PATIENT SERVICE REVENUE (L.5 - L.8 - L.10)	

APPENDIX C

DATA COLLECTED BY RSC 401

Data Collected by RSC 401

Balance sheet

Departmental revenue by type (inpatient, newborns, ambulatory)

Departmental revenue by payor

Statistical data on inpatient days, percentage occupancy and length of stay by class of accommodation, maternity statistics, and ambulatory statistics

Departmental expenses and an allocation of overhead expenses to revenue producing departments

Schedules of non-patient and non-operating expenses

Ancillary department statistics and cost allocated to inpatient, outpatient and non-patient

Departmental expenses categorized as salaries/wages, physician compensation, purchased services, supplies and expenses, major movable depreciation

Cost and revenue in routine service areas classified as medical surgical, obstetrics, pediatrics,psychiatry, etc.

Full time equivalent data by departments

An analysis of indebtedness and interest expense

Utilization statistics

APPENDIX D

PERSONS WHO PROVIDED INFORMATION
USED IN THIS CASE STUDY

PERSONS WHO PROVIDED INFORMATION USED IN THIS CASE STUDY

Dr. Louis Alfano
Executive Director
Blue Shield of Massachusetts

Mr. Peter Bloomsburgh
Assistant Commissioner
Department of Public Welfare

Mr. Arthur Carty
President
Blue Cross of Massachusetts

Mr. Ray Cisneros
Chief Fiscal Officer
Hospital of Good Samaritan

Mr. Howard Cohen
Boston Health Systems Agency

Mr. John Daley
Executive Secretary
Massachusetts Rate Setting Commission

Ms. June DiDonato
Operations Manager
Massachusetts Rate Setting Commission

Ms. Robin Dimeiri
Legal Counsel
Massachusetts Rate Setting Commission

Mr. Henry DiPrete
Vice President, Group Operations
John Hancock Mutual Life Insurance Co.

Ms. Lucy Farmer
Legislative Assistant

Dr. Jonathan Fielding
Former Commissioner
State Department of Health

Ms. Sally Foster
Massachusetts Rate Setting Commission

Mr. Tom Gagnon
Program Manager, Medicaid
Massachusetts Rate Setting Commission

Ms. Cheryl Goodman
Massachusetts Rate Setting Commission

Mr. Steven Haggarty
Vice President
Financial Affairs
Massachusetts Hospital Association

Mr. Robert Higgins
Executive Director
Central Massachusetts Health Systems Agency

Mr. Peter Hyams
Commissioner
Massachusetts Rate Setting Commission

Ms. Laura Jencks-Daley
Administrative Assistant
Massachusetts Rate Setting Commission

Mr. Jack Keane
Hospital Bureau Director
Massachusetts Rate Setting Commission

Mr. David Kinzer
Executive Director Local 380
Massachusetts Hospital Association

Mr. Luke Kraemer
Executive Officer, Local 380

Ms. Ellen Lutch
Director of Community Affairs
Massachusetts General Hospital Commission

Mr. Selby Mudarri
Commissioner
Massachusetts Rate Setting
Commission

Ms. Dorothy Pughy
Ernst and Ernst
Boston, Massachusetts
(Former Hospital Bureau
Director, Massachusetts
Rate Setting Commission)

Mr. Duke Rodriguez
Massachusetts Hospital
Association

Mr. Richard Rogan
Blue Cross of Massachusetts

Mr. Gerry Shea
Staff Director
Service Employee's Union

Mr. Charles Stover
Commissioner
Massachusetts Rate Setting
Commission

Mr. Paul Vielkind
Director of Finance
Carney Hospital

Mr. Steven Weiner
Center for Law and Health
Sciences
Boston University School
of Law
(Former Commissioner,
Massachusetts Rate Setting
Commission)

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